Speech Case History Form
Child

Name (Child) | Date of Birth (Child)

First | Last | MM/DD/YYYY

☐ Male ☐ Female

Home Address

Street Address

City | State | Zip Code

Home Phone

Form Completed By: ☐ Mother ☐ Father ☐ Guardian ☐ Caregiver ☐ Other:

Family Information

Parent/Guardian Name

Relationship to Child | Age

Occupation | Alternative Phone

Address | City/State | Zip Code

Parent/Guardian Name

Relationship to Child | Age

Occupation | Alternative Phone

Address | City/State | Zip Code

Siblings

Name | Age

Name | Age

Name | Age

Family Physician

Name | Phone

Street Address

City | State | Zip Code

STATEMENT OF PROBLEMS

Describe the concerns regarding your child's communication skills at this time:

Are there any skills the child had learned previously, but can no longer use? ☐ Yes ☐ No
If yes, please provide a brief description:

Has the child's hearing been tested? ☐ Yes ☐ No
If yes, where was the test completed:

Date Completed

(If yes, please bring a copy of the hearing test results to your appointment)

Results of Hearing Test: ☐ Hearing within Normal Limits ☐ Hearing Loss ☐ Further Testing Required

FAMILY TABLE

Have any family members had any speech, language, hearing problems, or learning difficulties?
If yes, provide a brief description: ☐ Yes ☐ No

What languages are spoken in the home?

What is the primary language used with this child?

Was this child adopted? ☐ Yes ☐ No
If yes, at what age?

Age | Location of Adoption

MEDICAL HISTORY

Name of Child's Physician

Medical Office

Describe the mother's health during pregnancy: ☐ Good ☐ Fair ☐ Poor

Were there any unusual conditions or problems during the pregnancy or birth? ☐ Yes ☐ No
If yes, provide a brief description:

Were there any drugs or alcohol consumed during the pregnancy? ☐ Yes ☐ No
If yes, provide a brief description:

Was the pregnancy full term? Yes No
If no, provide a brief description:

General Condition at Birth

Birth Weight

Does your child have any medically diagnosed illness or conditions? Yes No
If yes, provide a brief description:

Is your child taking any medications? Yes No
If yes, provide a brief description:

Has your child experienced any of the following?

Frequent Colds Seizures Sneezing Mouth Breathing Sleeping Problems

Frequent Ear Infections Other _____

Has your child had any surgeries, accidents or hospitalizations? Yes No
If yes, provide a brief description:

Are there or have there been any feeding problems (e.g., sucking, swallowing, drooling, chewing, etc.)
If yes, provide a brief description: Yes No

Is there anything else we should know about your child's medical history? Yes No
If yes, provide a brief description:

Has your child had any of the following evaluations or assessments? Please indicate:

☐ Hearing ☐ Speech & Language ☐ Psychological ☐ Physical Therapy ☐ Neurological

☐ Occupational Therapy ☐ Developmental ☐ Vision

Briefly describe the results:

Has your child received any of the following services?

☐ Speech/Language ☐ Occupational Therapy ☐ Physical Therapy ☐ Nursing

(Please be sure to bring copies of any evaluations, treatment plans, or IEPs, etc.)

DEVELOPMENTAL HISTORY

Please provide the approximate age at which the child acquired the following skills. If you can't remember the age, check the box that best describes when he/she acquired the skill as compared to his/her peers.

Sit:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Crawl:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Roll Over:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Walk:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Walk up/ down stairs:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Feed Self:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Dress Self:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Use Toilet:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers

How would you describe your child's motor development (running, skipping, grasping crayons/pencils) as compared to his/her peers?

SPEECH & LANGUAGE HISTORY

Please provide the approximate age at which the child acquired the following skills. If you can't remember the age, check the box that bestdescribes when he/she acquired the skill as compared to his/her peers.

Babbling (e.g.,"ba,ba"):	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Use First Words:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Put 2-3 words together:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Make Sentences:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Put sentences together:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Engage in Conversation:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers
Understand Directions:	Age	☐ Earlier than Peers	☐ Same as Peers	☐ Later than Peers

How does your child usually communicate (check all that apply)?

☐ Gestures ☐ Single Words ☐ Short Phrases ☐ Sentences

In what situations does the child have more difficulty communicating?

☐ At Home ☐ At Daycare/Preschool ☐ At School ☐ With Friends ☐ Everywhere

Has the problem changed since it was first noticed? Yes No

If yes, provide a brief description:

Approximately how much of your child's speech do you understand?

☐ Less than 10% ☐ 25% ☐ 50% ☐ 75% ☐ 90–100%

Approximately how much of your child's speech do those less familiar with the child understand?

☐ Less than 10% ☐ 25% ☐ 50% ☐ 75% ☐ 90–100%

BEHAVIOR HISTORY

Does your child seem unusually quiet?	Often	Sometimes	Never
Does your child seem to be restless or fidgety?	Often	Sometimes	Never
Does your child get upset easily?	Often	Sometimes	Never
Does your child rock his/her body?	Often	Sometimes	Never
Does your child enjoy "messy" play?	Often	Sometimes	Never
Does your child bump or push others?	Often	Sometimes	Never
Does your child pinch, bite, or hurt oneself?	Often	Sometimes	Never
Does your child have a difficult time with change?	Often	Sometimes	Never
Is your child easily distracted?	Often	Sometimes	Never
Does your child understand personal safety?	Often	Sometimes	Never
Does your child enjoy the company of other children?	Often	Sometimes	Never
Does your child enjoy reading or having books read to him?	Often	Sometimes	Never

Describe your child: (Check all that apply)

Friendly Shy Cooperative Independent Stubborn Difficult to Handle

Other _____

Do you have any concerns about your child's behavior? If so, please describe:

EDUCATIONAL INFORMATION

Is your child currently attending school: Daycare Preschool/School Head Start

Which school does your child attend?

How many hours per week does your child attend school?

How is your child doing in the program?

Does your child receive any special services at school? Yes | No
If yes, provide a brief description:

How does your child interact with others (e.g., friendly, shy, cooperative, etc.)?

Do you have any concerns about your child's behavior at school? | Yes | No
If yes, provide a brief description:

ADDITIONAL INFORMATION

What changes would you like to see in your child's development within the next year?

What do you see as your child's strengths?

What does your child enjoy playing with or enjoy doing?

Is there a teacher or caregiver who we may contact to gather further information about your child?
If yes, please identify below: | Yes | No

Name	Position	Phone
Name	Position	Phone
Name	Position	Phone

I authorize Without Limits, Speech Therapy of Winchester staff to contact the above person(s), as needed for the purpose of gathering information for my child's evaluation.

Parent/Guardian Signature

Signature

Date

Parent/Guardian Email

Email

Date of Evaluation

Date

Please mail this form to us as soon as possible:

Without Limits Speech Therapy
25 Battery Drive
Winchester, VA 22601

If it's not possible to mail this form, please be sure to bring it with you to the evaluation.

Thank you for taking the time to fill out this important information.