LITTLE EXPRESSIONS
SPEECH-LANGUAGE THERAPY

Speech-Language Case History Form

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Family Information/History

Child's Name: _____DOB: _____Sex: ❑ Male ❑ Female

Legal Guardian(s) Name: _____Phone #: _____Email: _____Primary Care Doctors Name: _____

Child Lives with (Check one):

❑ Birth Parents ❑ Foster Parents ❑ One Parent ❑ Adoptive Parent ❑ Parent & Step-parent ❑ Other_____

Is there a language other than English spoken in the home? ❑ Yes ❑ No

- If yes, which one? _____
- Does the child speak the language? ❑ Yes ❑ No
- Does the child understand the language? ❑ Yes ❑ No
- Who speaks the language? _____Which language does the child prefer to speak at home? _____

Medical History

Has your child experienced any of the following?

❑ Adenoidectomy	❑ Seizures	❑ Tonsillectomy	❑ Ear Infections How often_____	❑ Sinusitis	❑ Head Injury
❑ Encephalitis	❑ Sleeping Difficulties	❑ Ear Tubes	❑ Breathing difficulties	❑ Tonsillitis	❑ Feeding/Swallowing difficulties
❑ Vision Problems					

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? ❑ Yes ❑ No

If yes, why?_____

_____

Please list any medications your child takes regularly:

_____

Birth History

Length of Pregnancy _____weeks **Birthing Type**: ❑Natural Birth ❑Scheduled C-Section ❑Emergency C-Section ❑Scheduled Induction

Were there any complications at birth or with the pregnancy? ❑ Yes ❑ No NICU Stay? ❑ Yes ❑ No Length_____

If yes, please describe. _____

_____

Developmental History

Please provide the approximate age (months) at which the child acquired the following skills. (i.e., Write N/A if it does not apply).

	Activities of Daily Living			
	Babble	First Word	Walk	Use Toilet
Age (Months)				

Behavioral History

	Often	Sometimes	Never
Does your child seem unusually quiet?			
Does your child play alone for reasonable length of time?			
Does your child get upset easily?			
Does your child get easily distracted?			
Does your child have a difficult time with change?			
Does your child enjoy reading or having books read to him/her?			
Does your child like to try new things (food, activities, toys)			

Would you describe your child as…? (select all that apply)

❑ Friendly	❑ Shy	❑ Cooperative	❑ Independent	❑ Stubborn	❑ Fussy	❑ Difficult to handle
Other (Please Describe):						

Has your child had any of the following evaluations or assessments (Please check all that apply)?

❑ Hearing Date Last Tested: _____ Results: _____	❑ Speech-Language	❑ Psychological	❑Physical Therapy
❑ Occupational Therapy	❑ Neurological	❑Developmental	❑Vision

(If you checked any of the above)
What were the results (Please Describe)?

_____

Speech-Language History:

Name(s) of Others Living with Child	Relationship to child	Any Speech/Hearing/Learning Challenges? If yes, Explain….	Age	Sex

Do you feel your child has a speech/language problem? ❑ Yes ❑ No

If yes, please describe. _____

What types of sounds/words do you hear your child using (check all that apply)?

❑ Cooing ❑ Screeching ❑ Consonants ❑ Consonant and Vowel Combinations (e.g., bada, mama, da)

❑ Single Words ❑ Vowels ❑ 2-3-word phrases

RECEPTIVE LANGUAGE: What your child understands (Please check all that apply):

❑ Plays with objects/toys functionally/appropriately	❑ Follows Simple Directions (e.g., "Get the ball", 'clean up')	❑ Will look at named objects or people (e.g., will look at mom when you say where's mom')	❑ Responds to sounds other than voices.
❑ Takes multiple turns when playing with others	❑ Understands when you call them by name (e.g., look over, coo/babble)	❑ Bangs/shakes objects or toys together	❑ Plays Peek-a-Boo or other games with familiar people
❑ Understands the word 'no'	❑ Can maintains eye contact		

EXPRESSIVE LANGUAGE: How your child is currently communicating with others (Please check all that apply):

❑ Babbles consonants and vowels together (e.g. 'ba, pa, uuum')	❑ Combines more than one syllable together. (e.g., 'bada', 'bama', 'gagameee')	❑ Responds to yes/no questions	❑ Babbles repeated syllables repeatedly. (e.g., 'bababa', 'dadadada', 'mamamama')
❑ Uses Single Words If any, please list_____	❑ Uses gestures to communicate (e.g., reaching, pointing, guiding you to something)	❑ Requests assistance (e.g., help)	❑ Combines sounds together e.g., 'ba', 'apo', 'da', 'ee-uh'
❑ Puts 2-3 words together	. ❑ Waves 'hello' and/or 'goodbye'	❑ Imitates sounds/words	❑ Requests objects or people
Consonants Heard: ❑ 'p' ❑ 'm' ❑ 'b' ❑ 'n' ❑ 'w' ❑ 'h' ❑ 'k' ❑ 'g' ❑ 'd' ❑ 't' ❑ 'f'			
Vowels Heard: ❑ Short 'a' (hat) ❑ Long 'a' (ate) ❑ 'u' (to) ❑ Short 'o' (lot) ❑ Long 'o' (bow) ❑ 'uh' (up) ❑ Long 'e' (me) ❑ Short 'e' (bet) ❑ short 'I' (it) ❑ long 'I' (ice)			

FEEDING/SWALLOWING:

Are you concerned about any feeding/swallowing(e.g., problems with sucking, swallowing, drooling, chewing)? ❑ Yes ❑ No

If yes, Please explain _____

Would you consider your child as a 'picky' eater? ❑ Yes ❑ No

Does your child ever cough or choke after eating or drinking? ❑ Yes ❑ No

Does your child avoid any specific types of food? ❑ Yes ❑ No Which Foods?_____

If you checked '❑ Yes' on any of the above, please explain: _____

Additional Information:

What do you hope to gain from this evaluation? _____

Any Additional Comments/Concerns:_____