MONMOUTH UNIVERSITY

Monmouth University Center for Speech and Language Disorders

CHILD CASE HISTORY FORM

NAME:_____

DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____CELL PHONE:_____

PARENT/GUARDIAN EMAIL: _____

REFERRED BY:_____

PERSONAL INFORMATION

1. Who lives at home with the child (i.e. parents, siblings etc)?_____

3. Primary language spoken at home?_____

4. Does the child attend daycare/ nursery school? How often?_____

5. What social activities does your child engage in? Timeframe? _____

_____

SPEECH/LANGUAGE INFORMATION

1. Describe the child's speech/language problem

_____

_____

_____

2. Did your child exhibit any of the following difficulties:

□ delayed first words □ difficulty combining words into phrases/sentences □ decreased ability to answer questions

□ difficulty following commands □ decreased ability to engage in conversation □ speech is hard to understand

3. How does the child usually communicate or let you know what they need? (verbalizations, gestures)

_____

_____

_____

4. When was the problem first noticed? By whom?

_____

_____

_____

5. Has the problem changed since it was first noticed?

_____

_____

_____

6. Have any other speech/language specialists seen the child? What were their recommendations?

_____

_____

_____

7. Is the child aware of a problem or showing signs of frustrations? If so, please explain.

_____

_____

_____

8. Are there other family speech/language or hearing problems? If so, please explain.

_____

_____

9. Describe any behavioral concerns which child is currently displaying:

_____

10. Is your child:	Yes	No
A teeth grinder	___	___
A thumb sucker	___	___
A drooler	___	___
Prone to temper tantrums	___	___
Usually happy	___	___
Often frustrated	___	___
Shy	___	___
Plays well with others	___	___

PRE/POST NATAL HISTORY

1. Length of pregnancy_____
2. Type of delivery: □ Vaginal □ Caesarian
3. Any complications during pregnancy? _____
4. Any labor complications? (i.e. breech, fetal distress, low birth weight) _____

MEDICAL INFORMATION

1. Please check if your child has had any of the following. If so, at what age?

☐ Seizures	☐ Chicken Pox	☐ Croup	☐ Meningitis	☐ Asthma
☐ High fever	☐ Pneumonia	☐ Heart condition	☐ Ear infections	☐ Tonsillitis
☐ Colds	☐ Feeding difficulty	☐ Sleep difficulty	☐ Visual deficits	☐ Head trauma

2. Has child suffered a significant number of ear infections?_____
3. Has child had a hearing test? If so, what were the results?

   _____
4. Have your child's eyes been examined? If so, what were the results?

   _____

5. Has child had tubes placed in their ears (myringotomy with pressure equalizing (PE) tube insertion)?

_____

6. Has child experienced any major accidents or hospitalizations?

_____

_____

_____

7. Please list any specialists that have seen your child: (i.e. Neurologist, Psychologist, Otolaryngologist).

_____

8. Has child ever had any of the following? (please give dates):

   Tonsillectomy or Adenoidectomy_____

   Other operations_____

9. Has your child ever had any of the following?

   Convulsions_____

   Tongue-tied_____

   Broken teeth_____

   Other serious illness_____

10. Is child presently taking medications we should be aware of?

_____

_____

11. Please list food, medication or seasonal allergies

_____

_____

FEEDING HISTORY:

1. Was child bottle fed?_____ Breast fed?_____
2. How did child do taking bottle? Nursing?

   Describe:_____

   _____

3. How did child do eating baby foods?

   Describe:_____

   _____

4. At what age did child develop teeth?_____
5. At what age did child eat table food?_____
6. How well does child handle eating regular foods?

   Well_____Fair_____Poor_____

7. Does child ever choke during eating?

   Always_____Sometimes_____Never_____

8. Does child ever gag during eating:

   Always_____Sometimes_____Never_____

9. Does spillage occur from the mouth during meal time?

   Always_____Sometimes_____Never_____

10. At what age did child begin drinking from a cup?_____
11. Does child primarily drink from a "sippy cup"?_____
12. How does child handle the liquid?

    Well_____Fair_____Poor_____

PHYSICAL DEVELOPMENT:

1. At what age did child crawl?_____ Sit?_____Walk?_____
2. Does child show hand dominance?_____
3. Child's overall coordination: Good_____Fair_____Poor_____
4. Can child?

	Yes	No
Climb stairs	___	___
Run, jump, hop,	___	___
Dress himself (shirt, pants)	___	___

5. Is child:

	Yes	No
Clumsy	___	___

Awkward ___ ___

Holding pencil incorrectly ___ ___

Able to cut with scissors (over three years of age) ___ ___

6. Is child toilet trained? _____

LANGUAGE HISTORY:

1. Did child make cooing sounds?_____
2. At what age did child begin babbling?_____
3. At what age were child's first words?_____
4. At what age did child start speaking in sentences?_____
5. Is your child's speech understood by family members?_____

EDUCATIONAL HISTORY:

1. How is child doing academically?_____
2. What grade is he/she in? _____
3. Does child receive special services? (i.e., Early Intervention)_____

   _____

4. How does child interact with others? (Shy, aggressive,

   etc.)_____

   _____

   _____

5. Does your child have an Individualized Education Plan (IEP) Yes No

BEHAVIORAL INFORMATION:

1. Is your child showing signs of frustration or aware of a problem?

   _____

   _____

2. Have you been given any therapeutic strategies that helped your child (e.g., sensory, behavior plan, reward system)? If so, please list them here or provide a copy.

_____

_____

_____

GOALS:

1. What are your goals for your child?

   _____

   _____

2. If your child is older, do they express any goals for themselves?

   _____

   _____

Person completing form: _____

Relationship to client: _____

Signed: _____ Date: _____