

WALDRON COLLEGE OF HEALTH AND HUMAN SERVICES
Radford University Speech-Language and Hearing Clinic
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Pediatric Speech and Language Case History Form

General Information:

Date form completed: _____

Child's name: _____ Date of birth: _____

Gender: _____

Address: _____ Phone: _____

City: _____ Zip: _____

Email: _____

Person completing form: _____ Relationship to child: _____

Does the child live with both parents? _____

Mother's name: _____ Age: _____

Mother's occupation: _____ Business phone: _____

Father's name: _____ Age: _____

Father's occupation: _____ Business phone: _____

Referred by: _____ Phone: _____

Address: _____

Pediatrician: _____ Phone: _____

Address: _____

Family Doctor: _____ Phone: _____

Address: _____

Brothers and Sisters (Please include names and ages):

What language does the child speak? What is the child's primary language?

What languages are spoken in the home? What is the primary language spoken?

With whom does the child spend most of his or her time?

How does the child usually communicate (gestures, sounds, single words, short phrases, sentences)?

Describe the child's speech-language problem:

When was the problem first noticed? By whom?

What do you think may have caused the problem?

Has the problem changed since it was first noticed? (If yes, please describe):

Is the child aware of the problem? If yes, how does he or she feel about it?

What changes in the child's speech-language or hearing have you noticed since that time?

Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions? **Or Please list persons of clinics you have consulted about the problem?**

<u>Date</u>	<u>Name and Addresses</u>	<u>What were you told?</u>
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Have any other specialists (physicians, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Has the child ever had speech or language treatment? If yes, what was done in treatment?

Are there any other speech, language, or hearing problems in the family? If yes, please describe.

Maternal side of family? Yes_____ No_____

Paternal side of family? Yes_____ No_____

Both sides of the family? Yes_____ No_____

Speech, Language, and Hearing History

Does the child have any trouble sucking and/or nursing? Please describe:_____

Does it take an excessive length of time to drink a bottle?_____

Is there any regurgitation of liquids or solids through the nose?_____

Does the child have difficulty chewing meats?_____

While eating, does the child show signs of choking and/or gagging? Please describe:

At what age did the infant babble and coo?_____

At what age did the child say his/her first words?_____

At what age could the child identify objects by pointing?_____

At what age did the child follow simple directions such as "Give it to mommy?_____

When did the child begin to use two-word phrases?_____

Did speech learning ever seem to stop for a period of time? Please describe:_____

Do you question the child's ability to understand directions and conversation? If yes, why?_____

How well is the child understood by: parents _____,
 Brothers or sisters _____, playmates _____, and
 other adults _____

Does the child get stuck and/or repeat sounds or words? If yes, please describe:

Do you think the child hears adequately? _____ Do you think his/her hearing is
 constant or does it vary? _____

Does the child wear hearing aid(s) _____ Which ear? _____

What kind? _____

When did the child begin to wear a hearing aid (s)? _____

Who recommended it? _____

Does amplification help? _____

Does the child's voice seem normal to you? If no, please describe:

What do you think causes his/her voice to sound unusual? _____

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.)

Length of pregnancy: _____ Length of labor: _____

General condition: _____ Birth weight: _____

Circle type of delivery: head first feet first breech Caesarian

During this pregnancy did the mother have any of the following:

<u>Check if applicable</u>		<u>Month of Pregnancy</u>	<u>Hospitalization Necessary?</u>	<u>Check if applicable</u>		<u>Month of Pregnancy</u>	<u>Hospitalization Necessary?</u>
	Excessive vomiting				Kidney Disease		
	Bleeding				X-Rays		
	Swelling				Rh-negative		
	High Blood Pressure				Smoking		
	Low Blood Pressure				Diabetes		
	High fever				Hallucinogens		
	Convulsions				Toxemia		
	Excessive weight gain or loss				Surgery		
	Virus Infection				Accidents		
	German Measles (rubella)				Medications		
	Heart Condition				Miscarriage		
	Asthma				Other (specify)		
	Thyroid condition						

Were there any unusual conditions that may have affected the pregnancy or birth?

Birth weight? _____ Were instruments used? _____ Bruises? _____

Apgar score at 1 minute: _____ At 5 minutes: _____

Were there health problems during the first 2 weeks of infancy? _____

How long did the child remain in the hospital nursery? _____

Which hospital? _____

Check all that applied:

_____ Jaundice

_____ Transfusion

_____ Feeding difficulty

_____ Difficulty Breathing	_____ Tube Medications	_____ Oxygen Intravenous fluids
_____ Convulsions	_____ Infection	
_____ Incubator or Isolette	_____ Hemorrhage	

Medical History:

If appropriate, provide the approximate ages at which the child had the following illnesses and conditions:

Allergies: _____	Asthma: _____	Chicken Pox: _____
Colds: _____	Convulsions: _____	Croup: _____
Dizziness: _____	Draining Ear: _____	Ear Infections: _____
Encephalitis: _____	German Measles: _____	Headaches: _____
High Fever: _____	Influenza: _____	Mastoiditis: _____
Measles: _____	Meningitis: _____	Mumps: _____
Pneumonia: _____	Seizures: _____	Sinusitis: _____
Tinnitus: _____	Tonsillitis: _____	Other: _____

Has the child had any surgeries? If yes, what type and when (e.g. tonsillectomy, tube placement, etc)?

Describe any major accidents or hospitalizations:

_____	When? _____

Where? _____	

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify.

Does the child have any allergies? If yes, please describe and specify the type of reaction that occurs

Did the child have three or more ear infections (earaches, running ears) during the first year of his/her life?

Has the child's eardrum ever ruptured? _____

Has the child ever had tubes placed in his/her ears? _____
When? _____

Has the child had an ear infection within three months prior to this evaluation? _____

Have there been any changes that might have been stressful for your child (past and/or present, e.g. hospitalization, death of someone close, numerous moves, separations, divorce)? _____

Developmental History:

Provide the approximate age at which the child began to do the following activities:

Held head erect: _____	Rolled from back to stomach: _____
Played with hands: _____	Reached for objects: _____
Crawl: _____	Pulled self to sit: _____ Sit: _____
Pulled self to stand: _____	Stand: _____ Walk: _____
Walked alone: _____	Tied shoes: _____ Feed Self: _____
	Dress self: _____

Use toilet (toilet trained): _____
 Use single words (e.g., no, mom, doggie, etc.): _____
 Combine words (e.g., me go, daddy shoe, etc.): _____
 Name simple objects (e.g., dog, car, tree, etc.): _____
 Use simple questions (e.g., Where's doggie? etc.): _____
 Engage in conversation: _____
 Does the child lose balance or fall easily? _____

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)? If yes, describe.

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.).

Social and Education History:

Does the child tend to play alone, with other children, or adults?

Ages of playmates:_____ How does the child get along with other children?_____

With Adults?_____

Is it difficult to discipline your child? (Explain as fully as possible.)_____

Would you describe the child as happy or unhappy?_____

Is the child unusually quiet?_____ Unusually active?_____

Does your child have difficulty concentrating?_____

Difficulty sleeping?_____

Does anything else about the child's behavior concern you?_____

What are the child's favorite play activities?_____

If the child is school aged, please list recreational or after school activities that they enjoy?_____

Is the child currently enrolled in an educational program?

If yes, check current enrollment

Homeschool ____ Public ____ Private ____

Name of School: _____ Grade: _____

How is the child doing academically (or pre-academically)?

Does the child receive special services? If yes, describe.

How does the child interact with others (e.g., shy, aggressive, uncooperative, isolated, etc.)?

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals?

For your school-age child (or as much as this applies to your child), please check all that apply. Place two checks by areas that are very serious concerns.

<p>Reading:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Gains information from independent reading assignments at grade level <input type="checkbox"/> Identifies main ideas and details in reading <input type="checkbox"/> Follows written directions without difficulty <input type="checkbox"/> Is able to decode unfamiliar words <input type="checkbox"/> Can understand vocabulary in grade-level text <input type="checkbox"/> Can make inferences and/or predictions about reading <input type="checkbox"/> Understands story grammar (e.g., character, setting, Plot) <input type="checkbox"/> Can retell events from a story, event, movie, news report <input type="checkbox"/> Can paraphrase information read <p>Writing:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Expresses thought clearly in writing <input type="checkbox"/> Has legible handwriting <input type="checkbox"/> Uses adequate spelling <input type="checkbox"/> Uses correct punctuation <input type="checkbox"/> Uses complete sentences when writing <input type="checkbox"/> Uses various syntax structures (e.g. clauses, phrases, conjunction words) <input type="checkbox"/> Can perform on short-answer tests 	<p>Listening:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Follows oral directions the first time <input type="checkbox"/> Can understand oral presentations (class lectures, sermons) <input type="checkbox"/> Can answer questions based on information presented orally (audio books, CDs, movies) <input type="checkbox"/> Can later recall and relate information from orally presented materials <p>Speaking:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Speaks with adequate pronunciation, fluency and correct grammar <input type="checkbox"/> Uses age-appropriate complexity <input type="checkbox"/> Discusses everyday topics appropriately <input type="checkbox"/> Uses appropriate vocabulary <input type="checkbox"/> Can express opinions clearly <input type="checkbox"/> Ask questions when clarification is needed <input type="checkbox"/> Has no trouble finding words during speaking <input type="checkbox"/> Keeps to the point in speaking, without unnecessary repetition
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(Checklist adapted from Paul, R. (2007). Assessing Advanced Language. In R. Paul (3rd Ed.), Language disorders from infancy through adolescence: Assessment and Intervention (p. 578). St. Louis, MI: Mosby Elsevier.)

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem. (Please use back of page or add additional sheets if needed).

