

# Children's

Speech and Language Services, Inc.

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## CASE HISTORY FORM SPEECH, LANGUAGE AND HEARING DEVELOPMENT

Date \_\_\_\_\_

Child's Name \_\_\_\_\_  
Last First Middle Nickname

Birthdate \_\_\_\_\_

Parent's Names \_\_\_\_\_

Parent's Address \_\_\_\_\_  
Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work \_\_\_\_\_

Cell phone \_\_\_\_\_ e-mail \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Your relationship to patient \_\_\_\_\_

Person who recommended our services to you \_\_\_\_\_

Name of Pediatrician \_\_\_\_\_

Primary reason for bringing your child for this evaluation: \_\_\_\_\_

I Birth and Developmental History Yes No

A. Pregnancy

1. Was mother's condition during pregnancy good to excellent? \_\_\_\_\_

2. Were medications taken during pregnancy? \_\_\_\_\_

3. Were there any illnesses or complications during pregnancy? If yes, please give brief description. \_\_\_\_\_

4. Was baby born at term (due date) or within two weeks before or after due date? \_\_\_\_\_

5. What was birth weight? \_\_\_\_\_

6. Was the child adopted? \_\_\_\_\_

B. Labor and Delivery Yes No

1. Were labor and delivery normal? \_\_\_\_\_

2. Was labor induced? \_\_\_\_\_

3. Was there evidence of injury or poor health at birth?      \_\_\_ \_\_\_

4. During the first month of life, was child's health good to excellent?      \_\_\_ \_\_\_

C. Infancy and Early Childhood

1. Were there any feeding problems?      \_\_\_ \_\_\_

2. Was the baby of average activity level?      \_\_\_ \_\_\_

II. Medical History

1. Circle diseases child has had; note ages, severity, whether accompanied by high fever, and the effects:

<u>Disease</u>	<u>Age</u>	<u>Severity &amp; Effects</u>	<u>High Fever?</u>
Mumps	_____	_____	_____
Measles	_____	_____	_____
Chicken Pox	_____	_____	_____
Chronic Colds	_____	_____	_____
Tonsillitis	_____	_____	_____
Middle Ear Infections	_____	_____	_____
Allergies	_____	_____	_____
(Hay fever, asthma)	_____	_____	_____
Spasms, Convulsions	_____	_____	_____
Other	_____	_____	_____

<u>List Injuries and/or Operations</u>	<u>Age</u>	<u>Severity</u>	<u>Hospitalized?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Yes No

2. Is medication taken regularly for any reason?      \_\_\_ \_\_\_  
If so, what? \_\_\_\_\_  
Was development of teeth normal?      \_\_\_ \_\_\_

3. Please elaborate on the frequency of middle ear infections and their severity. Were antibiotics effective in treating the problem?

\_\_\_\_\_  
\_\_\_\_\_

III Social and Emotional Development

1. If your child exhibits or has exhibited the following behaviors, please indicate age at occurrence and whether you have attempted to deal with it:

<u>Behavior</u>	<u>Age (from)</u>	<u>Age (to)</u>	<u>Attempted to Alter these? (yes/no)</u>
Shyness	_____	_____	_____
Thumb Sucking	_____	_____	_____
Difficulty Separating from Parents	_____	_____	_____
Face Twitching	_____	_____	_____

<u>Behavior</u>	<u>Age (from) Age (to)</u>	<u>Attempted to Alter these? (yes/no)</u>
Strong Fears/Nightmares _____		
Temper Tantrums _____		
Sleeplessness _____		
Nervousness _____		
Difficulty Sitting Still _____		
Inability to Stay with One Activity Until Completion _____		
Negative Behaviors _____		
Bedwetting _____		

Yes No

2. Does the child have the opportunity to play with other children his age? \_\_\_ \_\_\_
3. If so, does he play with them? \_\_\_ \_\_\_
4. Does he play with younger children? \_\_\_ \_\_\_
5. Does he play with older children? \_\_\_ \_\_\_
6. Are you ever concerned because he doesn't play well with other children? \_\_\_ \_\_\_
7. What type of activity does your child prefer? \_\_\_\_\_  
\_\_\_\_\_
8. Primary type of discipline: spanking \_\_\_; isolation \_\_\_ (sending to room); verbal reasoning \_\_\_; other \_\_\_\_\_  
\_\_\_\_\_
9. Do you feel that your approach to discipline is effective? \_\_\_ \_\_\_

**IV. Motor Development**

1. Please indicate age when the following skills were first performed:

<u>Skill</u>	<u>Age</u>	<u>Skill</u>	<u>Age</u>
Creeping _____		Holding Cup _____	
Crawling _____		Using Spoon _____	
Sitting Unassisted _____		Using Fork _____	
Walking _____		Using Crayons _____	
Hopping _____		Using Scissors _____	
Skipping _____			

Yes No ?

2. Has the child established handedness? \_\_\_ \_\_\_ \_\_\_  
If so, which hand? \_\_\_\_\_
3. Indicate age when voluntary bladder control was achieved? \_\_\_\_\_ Bowel control? \_\_\_\_\_

4. Was there any difficulty in toilet training? \_\_\_\_\_

V. Speech and Language Development and Behavior

1. At what age did he/she babble? \_\_\_\_\_  
Imitate words? \_\_\_\_\_  
Use his first word meaningfully? \_\_\_\_\_  
Put words together? \_\_\_\_\_

2. Did speech and language skills seem to develop normally and then stop or regress? \_\_\_\_\_

3. Does he understand what is said to him? \_\_\_\_\_

4. Does he follow spoken directions? \_\_\_\_\_

5. Does he talk in (check all that apply):  
single words \_\_\_\_; phrases \_\_\_\_; complete but grammatically incorrect sentences \_\_\_\_;  
complete, grammatically correct sentences \_\_\_\_;  
other \_\_\_\_\_.

6. Does he retell stories or experiences that can be understood? \_\_\_\_\_

7. Does he often hesitate and/or repeat sounds and words? \_\_\_\_\_

8. Is his speech: too fast \_\_\_\_; too slow \_\_\_\_; average \_\_\_\_?

9. Is his voice: too soft \_\_\_\_; too loud \_\_\_\_; average loudness \_\_\_\_;  
hoarse \_\_\_\_; nasal \_\_\_\_; denasal (stuffed as during a cold \_\_\_\_);  
other \_\_\_\_.

10. Has he ever had speech or language therapy: yes \_\_\_\_\_ no \_\_\_\_\_

By whom? \_\_\_\_\_  
Where? \_\_\_\_\_

Dates? \_\_\_\_\_

VI. Auditory / Sensory Behaviors

1. Does your child seem to have a hearing difficulty? \_\_\_\_\_  
yes no

2. Is he inconsistent in his response to sounds and voices? \_\_\_\_\_  
yes no

3. Is your child overly sensitive to noise? touch? \_\_\_\_\_  
yes no

VII. Environmental History

**Names of Siblings**

**Birth Dates**

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**Others in the Home** \_\_\_\_\_

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**Briefly describe daily environment. Does your child attend day care or have a primary care provider who has English as a second language? If so, what language is spoken?**

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**Have any other family member or relatives had the following difficulties?**

**Difficulty** **Yes** **No** **Relationship to Child** \_\_\_\_\_

Speech or Language Problem \_\_\_\_\_

Hearing Problem \_\_\_\_\_

Learning Disability \_\_\_\_\_

Reading Problem \_\_\_\_\_

Emotional Problems \_\_\_\_\_

Mental Problems \_\_\_\_\_

**VIII. School History**

1. **Schools Attended** **Grade Level** **Dates** \_\_\_\_\_

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2. Does his schoolwork seem inadequate in any areas?                
yes no

If so, in what areas? \_\_\_\_\_

3. Please indicate present school hours  
Days of the week in attendance

**IX. Other Evaluations**

Has your child been seen by any other specialists?                
yes no

**Who?**

**Where? (Please list)**

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