Chit Chat Kids
Speech & Language Services

SPEECH-LANGUAGE-HEARING CASE HISTORY FORM

Client Information:

Child's Name: _____ Birthdate: _____

Age: _____ Gender: ___M ___ F

Best telephone number to call regarding appointments: _____

Best email contact: _____

Child lives with:

☐ Birth Parents ☐ Foster Parents ☐ One Parent
☐ Adoptive Parents ☐ Parent and Step-Parent ☐ Alternate Parents

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Mother's Name: _____ Occupation: _____
Last First

Cell Phone: _____

Address: _____

Father's Name: _____ Occupation: _____
Last First

Cell Phone: _____

Address (if different than above:)_____

Preferred contact (Mother): ☐ Preferred contact (Father): ☐

Client's Family Doctor: _____ Telephone: _____

Client's Pediatrician: _____ Telephone: _____

Client's Dentist (if applicable):_____ Telephone:_____

Client's Orthodontist (if applicable):_____ Telephone: _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Are there any relatives that have a history of speech-language-hearing difficulties?

☐ Mother: If yes, please describe. _____
☐ Father: If yes, please describe. _____
☐ Aunts: If yes, please describe. _____
☐ Uncles: If yes, please describe. _____
☐ Cousins: If yes, please describe. _____
☐ Grandparents: If yes, please describe. _____

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? _____

How long has the child been speaking his/her first language? _____

How long has the child been speaking English? _____

Speech-Language-Hearing

Do you feel your child has a speech problem? Yes ☐ No ☐
If yes, please describe. _____
Do you feel your child has a hearing problem? Yes ☐ No ☐
If yes, please describe. _____
Has he/she ever had a hearing evaluation/screening? Yes ☐ No ☐
If yes, where and when? _____
What were you told? _____
Has he/she ever had a speech evaluation/screening? Yes ☐ No ☐
If yes, where and when? _____
What were you told? _____
Has your child ever had speech therapy? Yes ☐ No ☐
If yes, where and when?_____
What was he/she working on?_____
Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? Yes ☐ No ☐
If yes, please describe_____
Is your child aware of, or frustrated by, any speech/language difficulties? _____
_____
What do you see as your child's most difficult problem in the home? _____
_____

Birth History

Was there anything unusual about the pregnancy or birth? Yes ☐ No ☐

If yes, please describe. _____

_____

How many months was the pregnancy? _____

Medical History

Has your child had any of the following?

☐ vision problems	☐ encephalitis	☐ seizures
☐ allergies (see below)	☐ high fevers	☐ sinusitis
☐ breathing difficulties	☐ head injury	☐ meningitis
☐ chicken pox	☐ mumps	☐ colds
☐ ear tubes	☐ ear infections (how many?)_____	
☐ Sleeping difficulties	☐ Thumb sucking (Age stopped: _____)	
☐ Difficulty chewing	☐ Used a pacifier (Age stopped: _____)	
☐ Frequent Congestion	☐ Bite his/her nails (Age stopped: _____)	
☐ Recurrent Tonsillitis	☐ Teeth Grinding/Clenching	
☐ Clicking or cracking in jaw	☐ Tonsillectomy (Age: ____)	
☐ Adenoids removed (Age: ____)	☐ Mouth breather Day: ☐ Night: ☐	

Have you been told that your child is “tongue tied”, or do you notice that the tissue under the tongue seems tight or restricted? (If this is the case, they will have difficulty sticking the tongue out, or lifting it to the roof of the mouth). Yes ☐ No ☐

Have you noticed, or been told by your dentist, that your child has an “open bite”, or can you see that the front teeth do not meet while biting? Yes ☐ No ☐

Describe any major accidents / injuries, surgeries, or hospitalizations: _____

_____

Does your child have any medical diagnoses? ADD, autism, dyslexia, Down Syndrome?

_____

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

If yes, why? _____

Please list any medications your child takes regularly: _____

Please list any known allergies: _____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

sat alone _____ grasped crayon/pencil _____

toilet trained _____ walked _____

babbled _____ said first words _____

put two words together _____ spoke in short sentences _____

Does your child...

Yes ☐ No ☐ Choke on food or liquids?

Yes ☐ No ☐ Currently put toys/objects in his/her mouth?

Yes ☐ No ☐ Brush his/her teeth and/or allow brushing?

Please describe your child's gross motor skills (coordinated, clumsy, falls a lot, slow, etc.) while walking, running, climbing, riding bikes, roller skating, etc. _____

_____

Please describe your child's fine motor skills while attempting to color, write, draw, cut with scissors, feed him/herself with utensils, etc. _____

Indicate with a checkmark any items that are difficult for you child:

☐ Eating a variety of foods

☐ Following directions or routines

☐ Answering questions

☐ Singing songs/reciting nursery rhymes

☐ Recognizing “common” words

☐ Rhyming

☐ Telling stories

☐ Receiving/giving hugs

☐ Eye-Hand coordination

☐ Blowing bubbles

☐ Understanding what he/she hears

☐ Think of words for things

☐ Pronouncing words correctly

☐ Stating sounds of letters

☐ Writing his/her name

☐ Getting his/her point across

☐ Self-calming

☐ Keeping shoes on

☐ Using a straw

☐ Keeping hands to himself/herself

☐ Speaking in organized or grammatically correct sentences

Current Speech-Language-Hearing

Does your child...

Yes ☐ No ☐ Understand what you are saying?
Yes ☐ No ☐ Point to common objects upon request (ball, cup, shoe)?
Yes ☐ No ☐ Follow simple directions ("Shut the door" or "Get your shoes")?
Yes ☐ No ☐ Respond correctly to yes/no questions?
Yes ☐ No ☐ Respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

☐ body language.
☐ sounds (vowels, grunting).
☐ words (shoe, doggy, up).
☐ 2 to 4 word sentences.
☐ sentences longer than four words.

Speech Sounds:

Yes ☐ No ☐ Can you understand what your child is saying?
Yes ☐ No ☐ Do people outside of the home find it difficult to understand your child?

Fluency:

Yes ☐ No ☐ Does your child repeat initial sounds many times (i.e.: m-m-m-m- mom?)
Yes ☐ No ☐ Does your child ever repeat words many times (i.e.: I want, I want, I want a cracker)

Social Pragmatics:

Yes ☐ No ☐ Can your child have back and forth conversation with you, friends, or siblings?
Yes ☐ No ☐ Get his/her point across?
Yes ☐ No ☐ Begin a conversation?
Yes ☐ No ☐ Stay on topic?
Yes ☐ No ☐ Interpret body language and/or facial expressions?
Yes ☐ No ☐ Does your child play with other children?

Are the interactions:

Yes ☐ No ☐ Friendly?
Yes ☐ No ☐ Withdrawn/Shy?
Yes ☐ No ☐ Aggressive?

Behavioral Characteristics:

Yes ☐ No ☐	Cooperative	Yes ☐ No ☐	Attentive
Yes ☐ No ☐	Stubborn	Yes ☐ No ☐	Restless
Yes ☐ No ☐	Separation difficulties	Yes ☐ No ☐	Poor eye contact
Yes ☐ No ☐	Inappropriate behavior	Yes ☐ No ☐	Self-abusive behavior
Yes ☐ No ☐	Willing to try new activities		
Yes ☐ No ☐	Easily frustrated/impulsive		
Yes ☐ No ☐	Easily distracted/short attention		
Yes ☐ No ☐	Plays alone for reasonable length of time		

School History

Name of School: _____

Grade in school: _____Teacher's Name: _____

Has your child repeated a grade? _____

What are your child's strengths and/or best subjects? _____

Is your child having difficulty and/or receiving help with any subjects?_____

_____

Please describe any special services your child is receiving? _____

_____

Does your child have an Individualized Program Plan (IPP)? _____

_____

_____

Additional Comments:

_____

_____

Who can we thank for your referral? _____

Do you have insurance coverage for Speech Language Pathologist Services? ☐ Yes ☐ No

Person completing form: _____ Date: _____D _____M_____Y

Relationship to child: _____

Thank you for taking the time to complete this form! We will review the information during our initial visit.