Twomey Speech & Language Services
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Diagnostic and Speech-Language Therapy Services

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Case History

Today's Date:_____

1. General Information

Child's Full Name:_____ Sex: M F Nickname:_____
Date of Birth:_____ Age:_____ Home Phone:_____
Street Address:_____
City:_____ State:_____ Zip:_____

Person(s) completing form:_____ Rel. to Child:_____

Mother's Name:_____ Home Phone:_____
Street Address:_____
City:_____ State:_____ Zip:_____
Mother's place of work:_____ Occupation:_____
Work Phone:_____ Cell Phone:_____ Email:_____

Father's Name:_____ Home Phone:_____
Street Address:_____
City:_____ State:_____ Zip:_____
Father's place of work:_____ Occupation:_____
Work Phone:_____ Cell Phone:_____ Email:_____

Parent's Marital Status:_____
Child lives with: ___Both parents ___Mother ___Father ___Other Adult (please specify)_____

Is your child adopted? __Yes __No At what age?_____ Has he/she been informed?___Yes ___No
Information regarding birth mother / early history / family history:_____

Has any member of your biological family been challenged by problems in any of the following areas: speech/language, hearing, learning, attention, organization, medical, and/or behavior problems? If so, please describe:_____

Names and ages of siblings:_____

Are there other adults/children living in your home? (Please specify)_____

Child's daytime caregiver?_____
Child's Primary Language:_____ Language(s) Spoken at Home:_____

Has your child been exposed to sign language?_____

Teacher's Name:_____ Grade:_____
If in Pre-school, Pre-K or Kindergarten; Days and Times:_____

School:_____ Town:_____
Type of Classroom:_____

2. Health Insurance / Physician

Name of Health Insurance Company:_____
Subscriber:_____
Subscriber's Insurance I.D. Number:_____
Subscriber's Date of Birth:_____
(Please attach a copy of the front and back of your insurance card.)

Primary Care Physician:_____
Address:_____
City:_____ State:_____ Zip:_____
Office Phone:_____

3. Presenting Concerns

Please describe the concerns you have for your child._____

When did you first notice these problems?_____

How have you supported your child's difficulties?_____

Has your child received previous Evaluations? (i.e., Speech-Language, Neurological, Developmental, Neuropsychological, etc.)_____

Has your child received speech and/or language services and/or other therapies in the past? Please describe:

Please list the names of other professionals that have evaluated or treated your child, note any diagnosis made, as well as dates of service. Please attach copies of evaluation(s) / progress report(s).
1._____
2._____
3._____

Does your child currently receive speech-language or other special services? Frequency? Please describe:

Does your child have an IEP? If yes, please attach a copy of the most recent IEP and progress report.

What is your goal in seeking this speech-language evaluation and/or treatment (i.e., increased correct production of specific speech sounds, improvement in speech intelligibility, growth in receptive and/or expressive language development, social use of language, etc.)?

4. Medical History

Has your child had any specialized medical tests performed? (i.e., EEG, MRI, etc.) Please list:

Has your child ever been hospitalized? Please describe:

Is your child currently being treated for any medical condition(s)?

List any current medications and dosages:

Does your child have any allergies to medications? Please specify:

Other allergies? Please list:

List any health precautions, limitations, or diet restrictions:

Does your child use any assistive devices (such as glasses, hearing aids, braces, etc.)?
If yes, please list:

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (please list and describe any complications):

Operations:

Hospitalization for illness(es) other than operations:

Head injuries:
_____with unconsciousness_____without unconsciousness
Seizures, convulsions, or staring spells?

_____with fever_____without fever

Coma:
Meningitis or encephalitis:
Immunization reactions:
Persistent high fevers: Highest temperature ever recorded:
Poisoning:

Eye Problems:
Date of last Vision Test:
Problems/Results:

Ear problems (please note the prevalence of ear infections and when):

Date of last Hearing Test:
Problems/Results:

Comments regarding medical history:

5. Developmental History

Birth History	**Yes**	**No**	**Comments**
Complications during Pregnancy?			
Prescribed bed rest?			
Spontaneous labor?			
Delivered at term (40 weeks)?			
Complications during labor?			
Complications during delivery?			
Vaginal delivery?			
Complications after delivery?			
Discharged with mother?			
Passed all newborn screenings?			
Birth weight:			
Birth weight appropriate for gestational age?			
Small for gestational age?			

Developmental Milestones	**Yes**	**No**	**Comments**
-Does/Did your child have any problems related to feeding, swallowing, or dietary concerns? Please explain:			
-Aversion to any textures of food? Please explain:			
-Used sounds and gestures to get/keep attention (7mos-1yr)?			
-Used 1 or 2 words by 1st birthday?			
-Put 2 words together like "more apple", "mommy book" by age 2 years?			
-Spoke understandably, putting 3 words together to talk about and ask for things by 3 years?			
-Read simple words by 6 years?			
-Please note when your child could sit up?			
-Crawled?			
-Age he/she began walking?			
-Toilet trained during the day by 3.5 years?			
-Dry at night by 5 years?			

Developmental Difficulties **Yes** **No** **Comments**

-Daytime or nighttime wetting?
-Bowel accidents?
-Sleep problems?
-Difficulty with self care (feeding, washing, toileting)?
-Difficulty learning to button, zip, dress?
-Difficulty learning to throw/catch a ball?
-Difficulty learning to name colors or shapes?
-Difficulty learning to name letters or numbers?
-Difficulty learning to ride a tricycle or bicycle?

Current Developmental Skills **Average** **Young**

-Ability to understand spoken sentences / directions (Receptive Language)
-Pronounces words clearly (Articulation)
-Ability to talk and use complete sentences (Expressive Language)
-Conversation skills including turn taking / commenting / requesting / initiating, etc.: the appropriate use of language socially in different situations (Pragmatic Language)
-Ability to make and keep friends (Social Skills)
-Ability to use fingers to write, draw, hold, and move objects (Fine Motor)
-Ability to use large muscles to run or play sports (Gross Motor)

Has your child's teacher described any problems academically? If so, please describe:

Comments on development or skills:

6. Behavioral History

Please describe any concerns you have about your child's behavior:

What behavioral strategies do you use at home?

How does your child respond to being told "no" or being corrected?

How does your child respond to praise, rewards, or positive reinforcement?

Are there any differences between your child's behavior at home and school?

Have your child's teachers described any behavior problems? If so, please describe:

7. Social History

Describe your child as an infant/toddler:

What is your child's temperament/personality like now?

How does your child get along with other members of the family?

Does your child seek friendships with peers?

Is your child sought by peers for friendship?

How does your child get along and play with peers / playmates?

Does your child play primarily with children his or her own age?_____ Younger?_____ Older?_____

What are your child's favorite toys, activities, sports, special interests?

8. Additional Comments

Please describe your child's strengths as well as the positive aspects of his/her personality and character:

Please summarize any additional information that you believe would help this speech-language pathologist in working with your child.

Thank you for your time completing this case history. The information you have shared will facilitate in planning appropriately for a speech-language evaluation and/or speech-language therapy services. I look forward to working with you and your child.