"We look forward to the opportunity to serve you and your child."

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SPEECH LANGUAGE CASE HISTORY

BACKGROUND INFORMATION

Name of Child:			Date of Birth:
Child's Address:			Age:
Gender:	SSN:	Is this child at school? ☐ Yes ☐ No	Foster Child? ☐ Yes ☐ No
Name of Guardian Completing the Form:		Guardian's Relationship to the Child:	
Guardian's Phone Numbers (Home/Work/Cell):		Guardian's Email Addresses (Personal/Work):	
Guardian's Address:			Preferred Contact Method: ☐ Phone ☐ Email
Primary Speech/Language Concern:			

FAMILY INFORMATION

Please list down all household members living with the child

Name	Relationship to the Child	Age/Occupation

FAMILY HISTORY

Question	Response	Details
Does your Family have a Speech/Language Difficulties?	☐ Yes ☐ No	Relationship to Child/Details if Applicable:
Does your Family have Learning Disabilities?	☐ Yes ☐ No	Relationship to Child/Details if Applicable:

LANGUAGE

Parents/Guardian's First Language:

Parents/Guardian's Secondary Language:

Primary Language at home:

How often is your child exposed to 1st Language vs 2nd Language (1st/2nd)?

☐ 90%/10% ☐ 80%/20% ☐ 70%/30% ☐ 60%/40%

What is your child's preferred language? ☐ Primary ☐ Secondary

Question	Response	Question	Response
Does your child understands the secondary language?	☐ Yes ☐ No	Does your child speak the secondary language?	☐ Yes ☐ No

SPEECH LANGUAGE HISTORY

Question	Response	Details
Has your child ever received a speech and language evaluation?	☐ Yes ☐ No	Date:
If yes, have they ever received speech and language therapy?	☐ Yes ☐ No	Date:

At what age did your child begin to

Babble: Use variegated babbling (jargons): First Words:

As a baby, your child

- ☐ Was “noisy”, made a variety of different consonants, sounds and intonations
- ☐ Made a limited number of consonants sounds and vocalization

Question	Response	Details
Did you become concerned about your child’s language and speech development?	☐ Yes ☐ No	When?

SPEECH LANGUAGE CURRENT LEVEL OF FUNCTIONING

Your child communicates to (can be more than one response):

- ☐ Request
- ☐ Protest
- ☐ Seek affection
- ☐ Comment
- ☐ Show

Your child uses the following strategies to communicate (can be more than one response):

- ☐ Whining/Crying
- ☐ Looking at you and then back at the object
- ☐ Grabbing your hand leading towards the desired object
- ☐ Reaching towards objects and pushing objects away
- ☐ Pointing/using gestures/nod/shakes head
- ☐ Using vocalizations or babbling
- ☐ Using single words
- ☐ Using 2-3 word phrases

Question			
Is your child aware of when he/she is not understood?		☐ Yes	☐ No
If yes, when your child is not understood what does she/he do?	☐ Become easily upset	☐ Adjust his/her mode of communication	☐ Not aware that she/he is not understood
My child points to familiar people and picture when named		☐ Yes	☐ No
My child indicates when her/his pants are wet		☐ Yes	☐ No
Answers choice questions (example: do you want cookies or crackers?)		☐ Yes	☐ No
Responds to simple directions or questions (sit down, come here)		☐ Yes	☐ No
Answers yes/no questions correctly		☐ Yes	☐ No
Answers where and what questions correctly		☐ Yes	☐ No
Responds to her/his name		☐ Yes	☐ No
Asks questions		☐ Yes	☐ No

DAYCARE

Question		
Does your child attend Daycare?	☐ Yes	☐ No
If yes, name of Daycare:		

How often does your child attend?		
Does your child currently have an active IFSP Plan?	☐ Yes	☐ No
Does your child receive school therapy services or early intervention through IEP or IFSP?	☐ Yes	☐ No
If yes, under what eligibility?		

Does she/he receive any other services? (can be more than one response)

☐ Special Education	☐ Occupational Therapy	☐ Physical Therapy	
☐ Behavior Intervention	☐ None	☐ Other	________________

Has your child's daycare staff expressed concern about how your child communicates, or how they interact with other children, or their behavior? If yes please explain:	☐ Yes	☐ No

MEDICAL HISTORY/INFORMATION

Physician/Pediatrician (Name & Facility):	Physician/Pediatrician's Phone Number:	
Primary Insurance Company:	Policy Holder's Name:	
	DOB:	SSN:
Secondary Insurance Company:	Policy Holder's Name:	
	DOB:	SSN:
Significant Medical Conditions, Surgeries or Injuries:		
Medications:		
Allergies:		

Please list down any significant prenatal or birth history:			
Length of Pregnancy (in weeks):	C-Section? ☐ Yes ☐ No	Emergency? ☐ Yes ☐ No	Planned? ☐ Yes ☐ No
Any Complications after Delivery?		NICU Stay? ☐ Yes ☐ No	How many weeks?
Has your child's hearing or vision been checked recently?		☐ Yes ☐ No	Results:
What are your Primary Areas of Concern?			
What are your Child's Strengths?			
What are your Family's Goals for Therapy?			
Please list down any behavioral or social concerns:			
Does your child use any adaptive equipment?		☐ Yes ☐ No	Details:
Is there anything else that you feel would be beneficial for us to know about your child?			
How did you know about us? Who can we thank for your referral?			

Thank you for taking the time to fill out this questionnaire. This information will help us become more familiar with your child so that we can provide the best service possible.

Parent's Name: ____

Parent/Guardian's Name: ______________________________ Relationship: __________________

Parent/Guardian's Signature: ____________________________ Date: ________________________