

RAINBOW SKIES SPEECH-LANGUAGE THERAPY

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SPEECH AND LANGUAGE CASE HISTORY

Child's Name: _____

Date of Birth: ____/____/____ **Gender:** ____ Male ____ Female

Address: _____

Street

City State Zip Code

Mother's Name: _____

Daytime phone number: _____

Home phone number: _____

Cell phone number: _____

Email address: _____

Father's Name: _____

Daytime phone number: _____

Home phone number: _____

Cell phone number: _____

Email address: _____

Other children in the family:

Name	Age	Gender	Grade	Speech, Hearing, Medical Problems
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is there another language besides English spoken in the home? ____yes ____no

If yes, which one? _____

Does your child speak the language? ____yes ____no

Does your child understand the language? ____yes ____no

Who speaks the language? _____

Which language does your child most typically speak at home? _____

REASON FOR REFERRAL

What are your concerns about your child's speech and/or language? _____

When did you first become aware of the problem? _____

Does your child appear aware of the problem? _____yes _____no

If yes, how does your child react to the problem? _____

How does your family react to the problem? _____

Has your child ever been treated for this problem before and if so where? _____

What questions do you hope to have answered from this evaluation? _____

Who referred you for this evaluation? _____

PRENATAL/BIRTH HISTORY

Were there any concerns or issues regarding the pregnancy? _____yes _____no

If yes, please explain. _____

At what week of pregnancy was your child delivered? _____

What was your child's birth weight? _____

Were there any concerns or issues regarding the delivery? _____yes _____no

If yes, please explain. _____

Was your child required to stay in the hospital after your discharge? _____yes _____no

If yes, please explain the reason and indicate how long your child remained in the hospital.

CHILD'S MEDICAL HISTORY

Who is the child's physician? _____

Are there any other doctors who provide care to your child? If yes please specify _____

Was your child ever hospitalized or in any major accidents? If yes, please explain. _____

Has your child ever had surgery (i.e. tonsillectomy, tubes in ears)? If yes, please explain what time and when? _____

Is your child taking any medications? If yes, please identify. _____

Does your child have allergies? If yes, please identify. _____

Has your child had any of the following illnesses? If yes please state approximate age:

- | | | |
|-----------------------------|--------------------------------|--------------------------|
| _____ Allergies | _____ Asthma | _____ Chicken Pox |
| _____ Croup | _____ Dizziness | _____ Ear Infections |
| _____ Encephalitis | _____ Frequent Colds | _____ Frequent Headaches |
| _____ Head Injury | _____ High Fevers | _____ Meningitis |
| _____ Pneumonia | _____ Respiratory Difficulties | _____ Seizures |
| _____ Sleeping Difficulties | _____ Vision Difficulties | _____ Other |

DENTAL HISTORY

1. Age at which first teeth erupted? _____
2. Are teeth currently healthy? _____yes _____no
3. Has your child ever been referred to an orthodontist? _____yes _____no
4. Has your child seen an orthodontist? _____yes _____no
5. Is your child using a dental prosthesis or appliance? _____yes _____no
6. Date of last dental visit? _____

SPEECH AND LANGUAGE DEVELOPMENT

How does your child primarily communicate his/her wants and needs?

- eye gaze pointing gestures physical manipulation
 crying vocalizations single words 2-3 word utterances
 sentences signs AAC device

Please indicate approximately when your child first demonstrated the following:

- cooing single words
 babbling (i.e. ba-ba, ma-ma) 2-3 word utterances
 jargon (own special language) sentences

Did your child use a pacifier or suck his/her thumb? If yes, please indicate at what age your child stopped. _____

Does your child have difficulty producing certain sounds? If yes, please identify: _____

Does your child hesitate, repeat, or “get stuck” on sounds or words? _____

Is your child’s voice:

- hyponasal hypernasal hoarse breathy

Does your child speak:

- too quickly too slowly too quietly too loudly

Which of the following best describes your child’s speech?

- easy to understand
 occasionally difficult to understand
 difficult for family to understand
 difficult for others to understand
 almost never understood

Which of the following best describes your child’s reaction to his/her communication problem?

- appears unaware of communication problem
 is easily frustrated when not understood
 tries to repeat sounds more clearly when asked
 tries to say something a “new” way when not understood
 is better understood when he/she tries
 has been teased about his/her speech

Which of the following does your child appear to understand?

- his/her name
- family names
- names of body parts
- colors/shapes
- names of objects
- simple directions
- complex and/or complex directions
- conversational speech

HEARING HISTORY

Do you have any concerns about your child's hearing? If yes, please explain why. _____

How old was your child when you first became concerned about his/her hearing? _____

Has your child had his/her hearing tested? If yes please explain further (i.e. when, by whom, results, recommendations, etc.) _____

Has your child's hearing: remained stable fluctuated progressively worsened

Has your child ever wore hearing aids or an FM system? If yes, please explain further (i.e., when, which ear, brand, etc.) _____

Did the amplification appear to help your child? Please explain. _____

Are you concerned about your child's ability to understand directions or conversations? If yes, what lead to these concerns? _____

Does your child demonstrate difficulty with any of the following:

- understanding in quiet
- understanding in noise
- hearing on the telephone
- hearing the radio/TV
- locating directions of sounds

_____ hearing one-on one

MOTOR DEVELOPMENT

Please indicate approximately at what age your child first accomplished the following:

_____ head support _____ reaching/grasping _____ sitting
_____ crawling _____ standing _____ walking
_____ climbing stairs _____ eating finger foods _____ eating with a spoon
_____ potty training _____ dressing self

Does your child have a hand preference? If “yes” which hand. _____

Does your child at times appear to be “clumsy”? _____yes _____no

Did your child have difficulty gaining weight as an infant? _____yes _____no

Does your child appear to drool excessively? _____yes _____no

Did your child ever exhibit any of the following difficulties during feeding?

_____ difficulty sucking or nursing
_____ excessive length of time to drink a bottle/complete a meal
_____ difficulty with certain textures of food (i.e. meat)
_____ reflux/ vomiting
_____ regurgitation of food/liquids through his/her nose
_____ choking
_____ eye tearing during meals
_____ allergies to food
_____ unusual eating habits

If yes to any of the above, please explain _____

Does your child eat with regular utensils? _____yes _____no

If adaptive equipment is needed for meals, please identify. _____

SOCIAL/EMOTIONAL DEVELOPMENT

Do you have any concerns regarding your child’s discipline/behavior? If yes, please explain.

Has your child ever been evaluated for emotional or behavior problems? If yes please explain.

Please check each item below that applies to your child's behavior.

- | | |
|---|---|
| <input type="checkbox"/> very quiet | <input type="checkbox"/> overly shy |
| <input type="checkbox"/> very active | <input type="checkbox"/> frequent tantrums |
| <input type="checkbox"/> defiant | <input type="checkbox"/> passive/easily controlled |
| <input type="checkbox"/> destructive | <input type="checkbox"/> nervous |
| <input type="checkbox"/> reliant upon routine | <input type="checkbox"/> separation difficulties |
| <input type="checkbox"/> imaginative | <input type="checkbox"/> friendly |
| <input type="checkbox"/> plays well with other children | <input type="checkbox"/> perfectionist |
| <input type="checkbox"/> prefers older children | <input type="checkbox"/> difficulty maintaining eye contact |
| <input type="checkbox"/> prefers younger children | <input type="checkbox"/> mouth breather |
| <input type="checkbox"/> prefers to play alone | <input type="checkbox"/> grinds teeth |
| <input type="checkbox"/> prefers adults | <input type="checkbox"/> unusual sleeping habits |

PLAY SKILLS

What are some of your child's favorite toys, television programs, books, songs, etc.

What are your child's dislikes? _____

What is the average length of time your child will attend to an activity? _____

Is your child easily distracted from play by any of the following?

- auditory stimuli (i.e. outside sounds, televisions, voices)
- visual stimuli (i.e. other toys/objects)
- other people in the room
- nearby activities

Please check the items below that best explain your child's play.

- | | | |
|--|--|--|
| <input type="checkbox"/> mouths toys | <input type="checkbox"/> bangs toys | <input type="checkbox"/> throws toys |
| <input type="checkbox"/> shakes toys | <input type="checkbox"/> pushes/pulls toys | <input type="checkbox"/> appropriate use of toys |
| <input type="checkbox"/> uses one object for another | <input type="checkbox"/> role plays | <input type="checkbox"/> make-believe play |
| <input type="checkbox"/> acts out familiar routines | <input type="checkbox"/> games with rules | <input type="checkbox"/> looking at books |
| <input type="checkbox"/> rough-&-tumble play | | |

EDUCATIONAL HISTORY

Does your child attend childcare or school? ____yes ____no

Where does your child attend classes and how often?

How many children are in your child's class? _____

Is your child in a traditional classroom? If "no" please identify type of classroom. _____

Does your child have any preference in learning style? ____visual ____auditory ____both

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

Does your child exhibit difficulty with his/her school performance? If "yes", please explain.

Has your child's teacher expressed any concerns about your child's school performance?

If "yes" please explain. _____

Has your child ever been evaluated or received any kind of therapy (i.e. Physical, Occupational)?

If "yes", please specify type of therapy and location, dates, and results of therapy.

Please include any other information that you feel may be of help to evaluate your child.

Please include any names and addresses to whom you would like to receive a copy of this evaluation.

Name _____

Agency _____

Address _____

City, State, Zip _____

Name _____
Agency _____
Address _____
City, State, Zip _____

Name _____
Agency _____
Address _____
City, State, Zip _____

Name of person completing form

Relationship to client

Signature of person completing form

Date