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
_____
_____
_____
_____

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.

_____very quiet
_____very active
_____defiant
_____destructive
_____reliant upon routine
_____imaginative
_____plays well with other children
_____prefers older children
_____prefers younger children
_____prefers to play alone
_____prefers adults
_____overly shy
_____frequent tantrums
_____passive/easily controlled
_____nervous
_____separation difficulties
_____friendly
_____perfectionist
_____difficulty maintaining eye contact
_____mouth breather
_____grinds teeth
_____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.

_____mouths toys _____bangs toys _____throws toys
_____shakes toys _____pushes/pulls toys _____appropriate use of toys
_____uses one object for another _____ role plays _____make-believe play
_____acts out familiar routines _____games with rules _____looking at books
_____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