

The Speech & Hearing Center

600 North Holtzclaw Avenue, Suite 200
Chattanooga, TN 37404-1240
423.622.6900

Child Speech Case History

Today's Date _____

Person completing this form: _____ Relationship to Child: _____

Who referred you to The Speech & Hearing Center? _____

Reason for Visit: _____

General Information

Child's Name _____ Name Usually Called _____

Birth Date _____ Age _____ Sex _____

Physician (Name and Address) _____

Speech and Language

Describe the child's current speech/language problem: _____

_____ Age of first spoken words

_____ Age of first spoken sentences

Describe the child's communication at the present time. (Please check all that apply.)

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Grunts and Points | <input type="checkbox"/> Copies What You Say | <input type="checkbox"/> Stutters |
| <input type="checkbox"/> Screams | <input type="checkbox"/> Single Words | <input type="checkbox"/> Too Soft |
| <input type="checkbox"/> Gestures | <input type="checkbox"/> Two-Word Phrases | <input type="checkbox"/> Too Loud |
| <input type="checkbox"/> Takes You to Object | <input type="checkbox"/> Longer Sentences | <input type="checkbox"/> Hoarse |
| <input type="checkbox"/> Copies What You Do | <input type="checkbox"/> Unclear Speech | |

Indicate any family history of speech or language problems: _____

Has child received any developmental evaluations prior to today? If "Yes," please explain. YES NO

School/Daycare: _____ Grade: _____

Is the child enrolled in any special education classes? YES NO

Has the child received previous speech/language therapy? YES NO

Is the child currently receiving speech/language services? YES NO

Comments about School: _____

Development

At what age did the following first occur?

_____ Sat Up Alone _____ Crawled

_____ Walked Unaided _____ Gained Bladder Control

Does the child appear clumsy or awkward? YES NO

Has the child received any intervention or therapy for motor development? YES NO

Prenatal/Birth History (Questions apply to the birth of this child.)

Mother's illnesses, accidents, or infections during pregnancy: _____

Which of the following did the mother experience during pregnancy?

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Drug/Alcohol Problems | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Surgery | <input type="checkbox"/> Accidental Injury |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Toxemia | |

Length of Pregnancy _____ Length of Labor _____

Any complications at delivery? _____

Did the child experience any of the following conditions immediately following birth?

- | | | |
|---|--|--|
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Oxygen Needed | <input type="checkbox"/> Feeding Problems |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sucking/Swallowing Problems |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Infections | |

Were there any other abnormalities or conditions not already mentioned? _____

Medical

Please check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> High Fever | <input type="checkbox"/> Other Injuries | <input type="checkbox"/> Eating or Swallowing Problems |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Wears Glasses |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Illnesses | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Operations | <input type="checkbox"/> Wears a Hearing Aid |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Medications | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diagnosed with ADHD/ADD | |
| <input type="checkbox"/> Head Injuries | | |

Please explain the items checked: _____

Describe any physical disability or condition: _____

Is the child currently taking any medications? If so, please list: _____

Family Information

Father's Name: _____ Mother's Name: _____

Father's Age: _____ Education: _____ Mother's Age: _____ Education: _____

Marital Status: Single Married Divorced Widowed Separated

Others Living in Child's Home:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____