458 All Sky Drive, Colorado Springs, CO 80921 ~ (719) 888-9555

Articulation Case History Form

Child's Name: ___________________________________ Date of Birth: _________________

Parent's Name(s): ________________________________ Home Phone : ________________

Home Address: __________________________________ Cell Phone: __________________

__________________________________ Work Phone: _________________

Parent's Occupation: ____

Email Address: ____

Child's School: __________________________ Grade: ____ Teacher: ___________________

Referred By: ____

Doctor's Name: ______________________________ Doctor's Phone: ___________________

Family History:

Child lives with (check one):

___ Birth Parents
___ Adoptive Parents
___ Parent & Step-parent
___ Foster Parents
___ One Parent
___ Other: ___________________

Siblings:

Name	Age	Name	Age

Does any **family member** have a history of:

	Yes/No	family member(s):
Speech/Language Difficulties	______	_____________________________
Hearing Impairment/Deafness	______	_____________________________
Thumb/finger sucking	______	_____________________________
TMJ/Migraines/Tongue Tie	______	_____________________________
Dental Malocclusion (open, over/under, cross bites)	______	_____________________________

If you responded "yes" to any of the above, please describe:

Date of last hearing screening: _______________ Results: _______________________

Date of last vision screening: ________________ Results: _______________________

Is there a language other than English spoken in the home? Yes____ No ____

If yes, which language? ___________________________________

Does the child speak this language? Yes____ No ____

Does the child understand this language? Yes____ No ____

Which language does the child prefer to speak at home? _________ school?_________

Feeding/Eating History: check all that apply (**past and present** behavior)

___ Thumb/finger sucking/pacifier (circle)
___ Open, over/under, cross bites (circle)
___ Early feeding difficulty
___ Pain when nursing for mother
___ History of thrush
___ Any drooling
___ Difficulty swallowing pills
___ Choking
___ Takes a long time to eat
___ Tongue Thrust
___ Teeth clenching/grinding (circle)
___ Sensitive gag reflex
___ Excessive drinking while eating
___ Weight gain issues
___ Reflux/Colic
___ Mouth breathing
___ Noticeable difficulty chewing or swallowing
___ Messy eater/Noisy eater (circle)
___ Bites rather than licks ice cream
___ Pulls lips in to clean (doesn't lick)
___ Bottle or ___ Breastfed: how long?____

Additional pertinent information:

Medical History: check all that apply:

___ Adenoidectomy
___ Chicken Pox
___ Frequent Ear Infections
___ Tonsillitis
___ Allergies
___ Ear (PE) Tubes
___ Head injury
___ Tonsillectomy
___ Breathing Difficulties
___ Frequent Colds
___ Sleeping Difficulties/snoring
___ Torticollis

If you checked any, please provide details/dates:

Hospitalizations: ____

Medications: ____

Does your child have food allergies/aversions? Yes____ No ____

If yes, please explain:____

Can your child have food/candy for occasional rewards? Yes____ No ____

Developmental History:

Please tell the approximate age your child reached the following milestones:

__________ Sat Alone
__________ Walked
__________ Babbled
__________ Put two words together
__________ Crawled
__________ Completed toilet training
__________ Said first word(s)
__________ Spoke in short sentences

Speech & Language Development:

Has your child ever received a speech/language evaluation? Yes____ No ____ Date ___________

Has your child received speech/language therapy previously? Yes____ No ____

If yes, when and for how long? ____

Is your child's speech difficult to understand? Yes____ No ____

Is your child aware of, or frustrated by, any speech difficulties? Yes____ No ____

Is your child reading? Yes____ No ____ Emerging ____

If no or emerging, please describe your child's reading/writing skill level:

Describe what type(s) of speech errors he/she exhibits and/or your current concerns: