Speech Assessment Case History Form

Child's name:		DOB:
Person completing form (relationship to child):		Today's date:
Child's race/ethnicity:	Gender:	Age:
Parent/Guardian name(s):		
Preferred phone #:	Other phone #(s):	
Address:		
Preferred email(s) for correspondence:		
Other email(s):		
Parents' occupation(s):		
Referred by:		
Doctor's name:	Doctor's phone:	

Family History

Child lives with: ☐ Birth parents ☐ Adoptive parent ☐ One Parent
☐ Parent & step-parent ☐ Foster parent(s) ☐ Other:

Siblings:	Name:	Age:	Name:	Age:

Do any close family members have a history of the following: Family member(s):

Speech/Language Difficulties ☐ YES ☐ NO
Learning Disabilities (ex: dyslexia) ☐ YES ☐ NO
Hearing Impairment/Deafness ☐ YES ☐ NO

If you responded "YES" to any of the above, please explain:

Is any 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?

Why is this speech evaluation being requested?

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Speech Assessment Case History Form (page 2)

Birth History

Was the child born premature? ☐ YES ☐ NO If yes, at how many weeks?

Was the child healthy at birth? ☐ YES ☐ NO If no, please explain:

Was there anything unusual about the pregnancy or delivery? ☐ YES ☐ NO

If yes, please explain:

Medical History

Check all that apply:

- ☐ Tonsillitis
- ☐ Adenoidectomy
- ☐ Tonsillectomy
- ☐ Difficulty sleeping
- ☐ Snoring
- ☐ Breathing difficulties
- ☐ Frequent colds
- ☐ Seasonal allergies
- ☐ Nasal congestion
- ☐ Chronic ear infections
- ☐ Hearing loss
- ☐ Ear (PE) tubes
- ☐ Vision problems
- ☐ Wears glasses
- ☐ Head Injuries
- ☐ Other medical/genetic diagnoses:

Additional medical information (surgeries, hospitalizations, medications, etc.):

Date of last hearing screening: Location: Results: ☐ Pass ☐ Fail

Date of last vision screening: Location: Results: ☐ Pass ☐ Fail

Feeding/Eating History

Check all that apply:

- ☐ Thumb/finger sucking
- ☐ Pacifier use
- ☐ Difficulty nursing
- ☐ Reflux/Colic
- ☐ Tongue thrust
- ☐ Messy eater
- ☐ Limited diet
- ☐ Food texture sensitivity
- ☐ Drooling observed
- ☐ Tongue or lip tie present
- ☐ Food allergies
- ☐ Weight issues
- ☐ Picky eater
- ☐ Choking/coughing while eating
- ☐ Sensitive gag reflex

If you checked any of the above, please explain:

Was your child... ☐ bottle fed or ☐ breastfed How long?

Does your child primarily breath through their... ☐ nose or ☐ mouth ☐ unsure

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Developmental History

Indicate the approximate age at which your child reached the following milestones:

_____	Sat alone	_____	Walked	_____	Grasped crayon/pencil
_____	Crawled	_____	Toilet trained	_____	Began to scribble/draw

Do you consider any physical/motor milestones to be delayed or impaired? ☐ Yes ☐ No

If yes, please explain:

Check all that apply:

☐ Unusually active/fidgety	☐ Low muscle tone	☐ Clumsy
☐ Easily overwhelmed	☐ Overly sensitive to sound	☐ Overly sensitive to touch

If you checked any of the above, please explain:

Has your child been diagnosed with a developmental disability or behavioral disorder? ☐ Yes ☐ No

If yes, please specify:

Educational/Academic History

	YES	NO
Does your child attend school?	☐	☐
Child's school/district:		
Teacher: Grade:		
Does your child have an active IFSP or IEP?	☐	☐
If yes, what service(s) does he/she receive?		
Does your child have an active 504 plan?	☐	☐
If yes, under what eligibility/diagnosis?		
Does your child receive any other therapies?	☐	☐
If yes, please list:		
Has your child ever received a speech/language evaluation?	☐	☐
If yes, when and by whom?		
Has your child received speech/language therapy previously?	☐	☐
If yes, when and by whom?		
Is your child reading?	☐	☐
Did they have or are they having a difficult time learning to read?	☐	☐
Is your chlid having difficulty with a particular subject?	☐	☐
If yes, which subject(s)?		
Has your child ever repeated a grade?	☐	☐
If so, what grade and why?		
Is your child receiving any other help at school/home (e.g., tutoring, etc.)?	☐	☐
If yes, please list?		

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Speech & Language Development

Indicate the approximate age at which your child reached the following milestones:

_____	Babbled	_____	Put two words together
_____	Said first words	_____	Spoke in short sentences

	YES	NO	Unsure
Was your child a quiet infant (limited vocalizations/babbling)?	☐	☐	☐
Did your child produce any consonant sounds in babbling by 12 months? (e.g., "mmm", "dah", etc.)	☐	☐	☐
Did your child produce consonant + vowel syllables by 18 months? (e.g., "doo", "buh", "no", etc.)	☐	☐	☐
Did/does your child produce /k/ or /g/ sounds in their babbling? (e.g., "goo", "gah", "kah", etc.)	☐	☐	☐
Did your child have 5 or more consonant sounds at 2 years old?	☐	☐	☐
Did/does your child prefer to use /m/, /p/, or /b/ sounds over others?	☐	☐	☐
Did anything concern you about your child's speech development?	☐	☐	☐

If yes or unsure, please explain: _____

Does your child prefer to communicate with: ☐ gestures ☐ words ☐ both ☐ neither

Does your child:	YES	NO
Follow simple directions?	☐	☐
Follow complex or multi-step directions?	☐	☐
Ask questions?	☐	☐
Understand what you are saying?	☐	☐
Identify objects and actions easily?	☐	☐
Respond correctly to yes/no questions?	☐	☐
Is your child's speech easily understood by most people?	☐	☐

If you checked "NO" for any of the above, please explain: _____

Is your child aware of or frustrated by any speech difficulties? ☐ YES ☐ NO

If yes, please explain: _____

What are your specific concerns regarding your child's speech? _____

Please provide some examples of a typical sentence or utterance your child says: _____

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