Graham Speech Therapy, LLC

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Pediatric Speech/Language Case History Form

Identifying Information:

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there a family history of :	Yes/No	family member(s):
Speech/Language Difficulties	_____	_____
Hearing Impairment/Deafness	_____	_____
Learning Difficulties	_____	_____
Developmental Difficulties	_____	_____

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

Date of last hearing screening: _____ Results: _____

Date of last vision screening: _____ Results: _____

Other Language Exposure:

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? _____

Birth & Medical History:

Was there anything unusual about the pregnancy or birth? Yes____ No ____

If yes, please explain:

How old was the mother when child was born? ____ How many months was the pregnancy? ____

Was the mother sick during pregnancy? _____ Birth Weight: _____

Has your child had any of the following:

Adenoidectomy	____	High Fevers	____
Allergies	____	Head injury	____
Breathing Difficulties	____	Sleeping Difficulties	____
Chicken Pox	____	Thumb/Finger Sucking	____
Frequent Colds	____	Tonsillectomy	____
Frequent Ear Infections	____	Tonsillitis	____
Ear (PE) Tubes	____	Vision Problems	____

If you checked any, please provide details/dates:

Other serious illness/injury: _____

Hospitalizations: _____

Medications: _____

Developmental History:

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

_____	Sat Alone	_____	Grasped crayon/pencil
_____	Babbled	_____	Crawled
_____	Said first word(s)	_____	Put two words together
_____	Spoke in short sentences	_____	Walked
_____	Completed toilet training		

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

If yes, please explain: _____

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

Speech & Language Development:

How does your child prefer to communicate?: gestures ___ words ___ both ___ neither___
Number of words in a typical sentence? _____ example: _____
Is your child's speech difficult to understand? Yes____ No ____
Describe what type(s) of speech errors he/she exhibits::

Does your child:

Identify objects? Yes____ No ____ Actions? Yes____ No ____
Ask questions? Yes____ No ____ Follow directions? Yes____ No ____
Understand what you are saying? Yes____ No ____
Respond correctly to yes/no questions? Yes____ No ____
Respond correctly to "WH" (who, what etc.) questions? Yes____ No ____

Please provide other examples of your child's speech/language:

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? _____

Please indicate your current concerns:

Is your child aware of, or frustrated by, any speech/language difficulties? Yes____ No ____
What do you see as your child's most difficult problem in the home?

School History:

Has your child ever repeated a grade? Yes____ No ____ If so, what grade? _____
What are your child's strengths and/or best subjects? _____
Is your child having difficulty with a particular subject? Yes____ No ____
If yes, what subject? _____
Is your child receiving help at school or at home (i.e., support services, tutoring, etc.)?
Yes____ No ____ If yes, please explain:

What do you see as your child's most difficult problem in school?

Favorite Activities: (Please list your child's favorite activities, hobbies, toys, games etc.)

Additional Concerns/Comments: