Nevada State Speech-Language Pathology Clinic

1300 Nevada State Drive

Henderson, Nevada 89002-9455

CHILD SPEECH-LANGUAGE CASE HISTORY FORM

General Information

Child Client' Name:		
Date of Birth:		
Address:		
Best Contact Email:		
Best Contact Phone:		
Fathers Name:	Age:	Occupation:
Fathers Address:		
Fathers Email:	Phone:	
Mothers Name:	Age:	Occupation:
Mothers Address:		
Mothers Email:	Phone:	
Referred By:		
Referral Email and/or Phone:		
Family Doctor:		
Address:		
Email and/or Phone:		

Other family members living with client:

Is the client: Hispanic/Latino Yes ☐ No ☐

Check one or more of the following groups in which the client is considered a member of:

American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐

Native Hawaiian or Other Pacific Islander ☐ White ☐

What Language(s) does your child speak? Does your child use sign language?

If more than one, which is the primary language in your home?

Which language system does your child prefer to use when communicating his or her needs/wants?

Describe you child's speech, language, and or/hearing problem.

How does your child communicate (e.g., gestures, sign language, single words, phrases, sentences)?

Does your child seem to be aware of his/her problem? If yes, what makes you think so?

What percentage of what your child says can be understood by his/her parents/guardians?

Is there any history of speech/language/hearing problems in any family members? If yes, please describe.

Does your child have any other problems or diagnoses that are influencing his/her development?

Has your child ever been seen for a speech or hearing evaluation or therapy? If yes, please give date(s), site(s), and results.

Has your child been seen by any other specialists? If yes, please explain.

Check any of the following that describe the behavior of your child:

Nervous or sensitive		Has no playmates	
Nightmares		Prefers to play alone	
Temper Tantrums		Easily managed	
Overactive		Overly talkative	
Cries easily		Touches, clings to others	
Likes school		Slow learner	
Behavior problem		Whiney	
Friendly		Separates easily from parents	
Enthusiastic		Cooperative	

Any concerns during prenatal or birth history? Yes ☐ No ☐

If yes, please answer the following questions.

If no, please skip to **section 3**,

Section (2): Prenatal and Birth History

Describe any unusual illness, condition, or accident during the pregnancy (German measles, RH incompatibility, etc).

Is there any history of miscarriages? If yes, please explain.

Was any medication taken during pregnancy? If yes, please list/describe.

Length of pregnancy: Length of labor: Birth weight:

Describe any problems during the delivery (breech birth, induced labor, etc).

Any medical concerns? Yes ☐ No ☐

If yes, please answer the following questions.

If not, please skip to **section 4**.

Section (3): Medical History

Provide approximate ages at which the child suffered any of the following illnesses and conditions:

Allergies:		Asthma:		Bronchitis:	
Chicken Pox:		Colds:		Convulsions:	
Croup:		Dizziness:		Draining Ear:	
Ear Infections:		Encephalitis:		Flu:	
Headaches:		Hearing Loss:		High Fever:	
Mastoiditis:		Measles:		Meningitis:	
Mumps:		Pneumonia:		Seizures:	
Sinusitis:		Stroke:		Sore Throat:	
Tinnitus:		Tonsillitis:			
Other:					

Does your child receive any medication at this time? If yes, please explain.

Does your child have any medication allergies? If yes, please explain.

Has your child had any surgeries? If yes, please provide age(s) and description(s).

Describe any major accidents.

Provide any additional information that might be helpful in the evaluation or remediation process.

Section (4): Developmental History

Provide approximate ages at which the child began to do any of the following:

Hold head up		Sit	
Stand		Walk	
Feed self		Dress self	
Toilet training		Toilet training ended	
Babble		Use of words	
Use two-word		Name objects	
Use simple		Engage in conversation	
Child's present weight		Child's present height	

Child's physical development has	Fast	☐	Normal	☐	Slow	☐
Child's coordination has been:	Good	☐	Average	☐	Clumsy	☐

Describe the child's response to sound (responds to all sounds, response to loud sounds only, etc).

If your child has hearing loss, please state the type of loss and age of onset.

If your child has hearing loss, please describe any assistive devices (hearing aids, etc).

Any concerns for feeding? Yes ☐ No ☐

If yes, please answer the following questions.

If no, please move to **section 6**.

Section (5): Feeding Milestones

Was your child breast-fed? If yes, for how long?

Does your child still breast feed? Yes ☐ No ☐

When was your child's first bottle? Did your child have any trouble with the bottle? If yes, please describe.

At what age did your child cereal?

Describe any problems encountered with spoon feeding cereal and other solids.

When was your child weaned from the breast or bottle to cup drinking?

Describe any problems with moving to cup drinking.

At what age did your child begin to eat foods that require biting and chewing?

Describe any problems with biting or chewing

Current Information

How would you describe your child's appetite?

Good	Fair	Poor	Varies

Please explain.

Describe a typical meal (include what your child eats and drinks and how much of each).

Breakfast:

Lunch:

Dinner:

Snack:

What consistency of food does your child eat? (Check all that apply)

Smooth baby food	☐	Semi-chunky baby food	☐	Breast milk	☐
Mashed table food	☐	Regular table food	☐		

What kind of liquid does your child drink? Regular (thin) liquids ☐ Thickened liquids ☐

If thickened liquids, what is used to thicken the liquid?

Which of the following does your child drink?

Cows milk	Soy milk	Breast milk	Formula

If your child is nursing, does mother have adequate production of milk?

How much of the following does your child eat and drink in a typical 24-hour period?

Food	Liquid	Supplements

Does your child drink juice? Yes ☐ No ☐

If yes, how much in a day?

When? (Check mark all that apply.) Before meals ☐ During meals ☐ After meals ☐

What are your child's favorites foods/liquids?

What temperature foods and liquids does your child prefer?

Room temperature	Warm	Cold

What are some food/liquids your child does not like/refuses?

What foods are easy for your child to eat?

What foods are difficult for your child to eat?

How many times a day does your child eat? How long is it between meals?

How long does each meal take?

Does your child use any special equipment to eat?

Bottle	Nipple	Cup	Spoon

If yes, please describe.

Does your child self-feed? Yes ☐ No ☐

If yes, how? (Check mark all that apply.) With fingers ☐ With spoon ☐ With fork ☐

Does your child hold any of these items independently?

Bottle	Cup with spout	Regular cup	None

What is your child's position when eating/being fed?

Held by a caregiver (Describe position.)	In high chair	In seating device

If held, please describe how the child is held.

Does your child eat more/less/same amount in the following situations?

With other relatives	More	Less	Same
With other adults (e.g. babysitter)	More	Less	Same
At school/daycare	More	Less	Same
With others	More	Less	Same

Does your child receive any supplemental feeding? Yes ☐ No ☐

If yes, please check:	NG	PEG	PEJ	oral supplements

Response to Feeding/Mealtime Interaction

Where does your child typically eat at home?

Who usually feeds your child?

Check any of the following that describe the behavior of your child during a meal:

Crying		Throwing food	
Spitting out food		Getting down from the	
Holding food in		Refusing to eat	
Gagging		Turning head away	
Vomiting		Clamping mouth shut	

When this happens, what do you do?

Section (6): Educational History

Is your child attending school? Yes ☐ No ☐

Have they ever had an evaluation completed at the school? Yes ☐ No ☐

If yes to either question, please answer the following questions.
If not, please sign on the **last page.**

School Name: Grade:

At what age did child start pre-school, kindergarten, or grade school?

Were any grades repeated?

What are your child's strongest subjects?

How is your child doing academically?

Describe your child's overall progress in school.

How does your child interact with others?

Does your child work with a speech therapist at school? If so, how much time per week do they need?

Does your child receive any special services? If yes, please describe.

If enrolled for special education services, has an Individualized Education Plan (IEP) been developed? If yes, describe the most important goals when initial placement began.

If your child receives special education services but is also mainstreamed in regular education classes, please list the classes for which your child is mainstreamed.

Nevada State University Speech-Language Clinic shall not discriminate on the basis of race, national origin, religion, age, sex, sexual orientation, or handicapping condition.

Person completing form:

Relationship to client:

Signature: _____ Date: _____

Email completed intake form to:

speechclinic@nevadastate.edu