PURDUE UNIVERSITY

DEPARTMENT OF SPEECH, LANGUAGE, AND HEARING SCIENCES

Child Speech-Language Case History

Today's Date: _____/____/_____
MM DD YYYY

General Information

Name of Child: _____ Date of Birth: _____/____/_____
Last First Middle MM DD YYYY

Address: _____
Street/P.O. Box City State Zip

Telephone: _____ E-mail: _____
Home Work Cell

Gender: _____ Race/Ethnicity: _____

Primary Language: _____ Secondary Language: _____

Primary Caregivers' Name	Age	Occupation	Education

If the address of either parent is different from that of the child, please indicate:

_____
Street/P.O. Box City State Zip

Additional People in the Household:

Relation	Name	Age

Who referred you to the speech clinic? _____
Child's Doctor: _____ Address: _____

Name of person filling out this questionnaire: _____ Relationship to Child: _____

Statement of the Problem

Describe the child's speech, language and/or hearing problems: _____

When was the problem first noticed and by whom? _____

What changes in your child's language and/or speech have you noticed since that time?

Is the child aware of the problem? Yes No
If Yes, how does he/she react? _____

_____

Do you have any idea of what may have caused the problem? Yes No
If Yes, please describe: _____

_____

Under what situations is the child's speech...

1. Better: _____

_____

2. Worse: _____

_____

Has the child ever had a speech-language evaluation? Yes No
If Yes, when and by whom? _____
What were the results? _____

_____

_____

Has the child ever received speech-language therapy? Yes No
If Yes, when and by whom? _____
For how long? _____
What were the results? _____

_____

_____

Have any relatives had speech and/or language problems? Yes No
If Yes, relationship to child: _____ *Type of problem:* _____

_____

How does your child usually communicate (gestures, single words, short phrases, sentences)?

_____

_____

Please check the appropriate column that describes your child in the chart below:

Child...	**Always**	**Frequently**	**Sometimes**	**Rarely**	**Never**	**Comment (if desired)**
Talks						
Is understood by parents/caretakers						
Is understood by other family members						
Is understood by peers						
Is understood by strangers						
Attempts to fix speech errors						
Can follow simple directions (e.g., get your shoes)						
Can follow a series of directions (e.g., put your socks away and turn out the light)						
Has difficulty remembering what you have told him/her						
Says "huh" when given directions or needs directions repeated						

Child...	Always	Frequently	Sometimes	Rarely	Never	Comment (if desired)
Understands common actions (e.g., run, eat, drink)						
Names common objects						
Names actions						
Can tell a simple story						
Can say a nursery rhyme						
Has a voice that sounds hoarse, strained, breathy						
Yells and/or makes sound effects						
Takes turns with conversational partner						
Makes eye contact						
Gets along with peers						
Gets along with adults						
Hesitates, "gets stuck", repeats or stutters on sounds or words						
Avoids saying certain words						
Enjoys being read to/reading						
Avoids speaking at school						
Avoids speaking in play situations						
Avoids speaking at home						
Avoids speaking to adults						
Cries when unable to communicate						
Becomes aggressive when unable to communicate						
Prefers to play alone						

Birth History

Is the child your biological child? Yes No
If No, please explain: _____

_____

_____

Did the mother have any medical problems during this pregnancy, labor or delivery? Yes No
If Yes, please describe: _____

_____

_____

Did the mother take any prescription and/or non-prescription medication during this pregnancy? Yes No
If Yes, what kinds? _____

_____

_____

Was the child full term? Yes No
If No, how many months premature? _____

Were there any problems with delivery or immediately after birth with the child? Yes No
If Yes, please describe: _____

_____

_____

Child's birth weight: _____

Did the infant have feeding problems? Yes No
If Yes, please describe: _____

_____

Developmental History

Give ages at which the following first occurred, if applicable (approximate ages are okay):

Milestone	Age	Milestone	Age
Held head up		Babbled/Cooed	
Sat unsupported		Said first word	
Crawled		Used two word sentences (e.g., me go)	
Reached for an object		Used three or more word sentences	
Stood		Fed self	
Walked		Bladder trained	
Ran		Bowel trained	
		Dressed self	

Did the child keep learning new words once s/he started to talk? Yes No
If No, please describe any changes in the child's speech: _____

_____

_____

Does your child make child make sounds incorrectly? Yes No
If Yes, please give examples: _____

_____

Which hand does the child use most frequently? Right Left No preference

Medical History

Give ages at which the following occurred, if applicable (approximate ages are okay):

	Age	Describe		Age	Describe
Adenoidectomy			High Fevers		
Allergies			Influenza		
Asthma			Measles		
Blood Disease			Meningitis		
Chicken pox			Mental Illness		
Chronic colds			Mumps		
Convulsions			Muscle Disorder		
Croup			Nerve Disorder		
Diphtheria			Orthodontia		

Dizziness			Pneumonia		
Ear Surgeries			Seizures		
Earaches or infections			Rheumatic fever		
Encephalitis			Sinusitis		
Eye Disorders			Tonsillitis		
Headaches			Whooping cough		
Head injuries			Other		
Heart problems			Other		

Describe any other illnesses, accidents, injuries, operations, and hospitalizations (include age):

_____

_____

_____

_____

Circle the child's current health: Good Fair Poor

Is the child now under medical treatment or on medication? Yes No
If Yes, please describe: _____

_____

Please list the information regarding the most recent exams below:

Type of Exam	Date	Name of professional	Results
Physical Exam			
Vision Test			
Hearing Test			
Psychological Evaluation			
Other:			

Does the child wear: Hearing aid Glasses

Educational History

Child attends (please circle): Day care Nursery Kindergarten Grade School Secondary School
Name of school: _____ Grade/Level: _____

Describe the child's academic performance: Below Average Average Above average

Has the child repeated a grade? Yes No *If Yes, which one(s)?* _____

What are the child's best subjects? _____

_____

What are the child's poorest subjects? _____

_____

What is your impression of the child's learning abilities? _____

_____

_____

Does the child receive any occupational therapy or physical therapy services? Yes No
If Yes, please describe: _____

_____

If enrolled for special education services, has an Individualized Education Program (IEP) been developed? Yes No

If Yes, describe the most important goals: _____

_____

_____

Daily Behavior/ Family Routines

Check these as they apply to your child:

	Yes	No	Describe (give ages, if applicable; approximate ages are okay)
Eating problems			
Sleeping problems			
Toilet training problems			
Difficulty concentrating, distractible			
Needs a lot of discipline			
Underactive			
Overactive			
Excitable			
Laughs easily			
Cries a lot			
Overly sensitive			
Makes friends easily			
Irritable			

Describe any other type(s) of behavior you feel is important for us to know: _____

_____

Describe activities/toys that the child enjoys: _____

_____

_____

Thank you for taking the time to complete this form completely. The information that you have given us will help us provide efficient and effective speech-language services.