Outsounding
Speech-Language Pathology Services

Speech-Language-Hearing 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: _____

Child lives with (check one):

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

Family History:

Siblings:	Age:
_____	_____
_____	_____
_____	_____

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

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

_____
_____
_____

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

If you checked any, please provide details/dates:

_____
_____
_____

Other serious illness/injury: _____
Date of last hearing screening: _____ Results: _____
Date of last vision screening: _____ Results: _____
Hospitalizations: _____
Medications: _____

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Developmental History:

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

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

Oral Motor & Feeding History:

Has your child experienced feeding/eating difficulties (e.g., biting, swallowing, chewing)?
Yes/No _____
If yes, please explain: _____
Was your child breast-fed or bottle-fed? _____
Does your child eat by self using utensils? Yes/No _____ Drool? _____
Does your child put toys in mouth? Yes/No _____
If yes, please explain: _____
Does your child have food allergies? Yes/No _____
If yes, please explain: _____
Does your child have food preferences/aversions? Yes/No _____
If yes, please explain: _____

Speech & Language Development:

How does your child prefer to communicate?
_____ gestures _____ words _____ both _____ neither

Number of words in a typical sentence? _____
Is your child's speech difficult to understand? _____
What types of speech errors does he/she exhibit?
_____
_____
_____

Does your child:
identify objects? _____ actions? _____ ask questions? _____
follow directions? _____ understand what you are saying? _____
respond correctly to yes/no questions? _____
respond correctly to "WH" (who, what etc.) questions? _____

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

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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? For how long? _____
Can your child have food for therapy and/or rewards? Yes/No _____
If yes, please list any exceptions: _____
Please indicate your current concerns:

_____
_____
_____

Is your child aware of, or frustrated by, any speech/language difficulties? _____
What do you see as your child's most difficult problem in the home?

_____
_____
_____

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

_____
_____
_____

School History:
Has your child ever repeated a grade? _____ If so, what grade? _____
What are your child's strengths and/or best subjects? _____
Is your child having difficulty with a particular subject? _____
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: _____

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

_____
_____
_____
_____

Additional Concerns/Comments:

_____
_____
_____
_____
_____