LAKESHORE
SPEECH THERAPY, LLC.

Speech-Language-Hearing Case History Form

Child's Name:	**Birthdate:**
Sex: M F	**Age:**
Mother's Name:	**Mother's:** **Cell #:** **Home #:** **Work #:**
Mother's Address:	**Mother's:** **Home email:** **Work email:**
Father's Name:	**Father's :** **Cell #:** **Home #:** **Work #:**
Father's Address:	**Father's :** **Home email:** **Work email:**
Doctor's Name:	**Doctor's Phone:**

Child lives with (check one):

☐ Birth parents ☐ Foster Parents ☐ One Parent

☐ Adoptive Parents ☐ Parent & Step-Parent ☐ Other _____

Family History:

Siblings: _____ Age: _____

_____ _____

_____ _____

Is there a past family history of speech, language or hearing problems or learning/developmental disabilities? ☐ Yes ☐ No

If "yes," please comment here:

_____

_____

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? _____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language: ☐ Yes ☐ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

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

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: _____

Developmental History:

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

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

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 or food allergies? Yes/No ____
If yes, please explain:
_____

<u>Speech & Language Development</u>:

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? _____
play appropriately with toys? _____
have difficulty with routines and/or transitions such as bedtime, mealtime, or getting in the car?_____

Please provide 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? 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:

School: _____
Grade: _____ Teacher: _____
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: _____
Does your child have an IEP? _____ If so, please briefly describe the services your child receives:

_____
_____
(Please also provide a copy of the IEP at your first appointment)

Favorite Activities:

Please list your child's favorite activities, hobbies, toys, games, t.v. shows, etc.

_____
_____
_____
_____
_____

What are their dislikes, if any:

_____
_____
_____

What are your child's strengths?

_____
_____
_____
_____

Additional Concerns/Comments:

_____
_____
_____
_____

Thank you so much for your cooperation in completing this form, it is crucial that we have this information so that we can provide the most effective evaluation and therapy services for your child.