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? _____

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: _____

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?

_____
_____
_____

<u>School History</u>:

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!