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? _____

Preferred language ate 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 _____Sensory concerns_____Tip Toe Walker_____

If you checked any, please provide details/dates:

_____

_____

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

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
_____ Puts 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? Yes/No Suck Thumb? Yes/No If yes, since what age? _____
Use pacifier? Yes/No If yes, since what age? _____

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: _____

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? _____
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!