

## **CHILD CASE HISTORY FORM**

Any client applying for services at the Ludden Speech and Language Clinic is required to receive a speech and language evaluation at this facility prior to scheduling. In order to prepare and conduct the most meaningful evaluation, we would like you to provide the following information. Please answer all questions as completely and accurately as possible.

If you have any other information from other professionals, such as medical records or school evaluations, please forward copies of those documents along with this case history form. If you have any questions, please feel free to contact us.

\*\*Please note this is not a peanut-free facility.

---

The Ludden Speech and Language Clinic maintains confidentiality of all client records, including any documentation which you provide from other facilities.

---

### GENERAL INFORMATION (Print Clearly)

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Preferred Name (if different): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address:

\_\_\_\_\_

(Street)

City/State

Zip Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other: \_\_\_\_\_ Email: \_\_\_\_\_

School \_\_\_\_\_ Grade or Type of Class \_\_\_\_\_

What is the child's primary language? \_\_\_\_\_

What is the parents' primary language? \_\_\_\_\_

Who is the child's primary caregiver? \_\_\_\_\_

What is the caregiver's primary language? \_\_\_\_\_

Does the child live with both parents? \_\_\_\_\_

If no, who is the child's legal guardian? \_\_\_\_\_

FAMILY INFORMATION

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_

Mother's Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_

Father's Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Brothers and Sisters (names and ages):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMERGENCY CONTACT INFORMATION

\_\_\_\_\_  
(Name) (Relationship)

Address of Emergency Contact:

\_\_\_\_\_  
(Street) City/State Zip Code

Phone Numbers of Emergency Contact:

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work: \_\_\_\_\_ Other: \_\_\_\_\_

Email: \_\_\_\_\_

REFERRAL INFORMATION

Referred By: \_\_\_\_\_

Profession of Person or Relationship to Client: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

SPEECH AND LANGUAGE **(This section must be completed.)**

What are your primary speech or language concerns?

RECEPTIVE LANGUAGE (check all that apply)My child *understands*:

\_\_\_\_\_ single words

\_\_\_\_\_ yes/no questions

\_\_\_\_\_ sentences

\_\_\_\_\_ wh-questions (e.g., where, when, who)

\_\_\_\_\_ routine requests (e.g., sit down, stop) \_\_\_\_\_ conversation

EXPRESSIVE LANGUAGE

At what age did your child:

babble? \_\_\_\_\_ say his/her first word? \_\_\_\_\_

combine words? \_\_\_\_\_ use sentences? \_\_\_\_\_

My child **currently** uses the following modes of communication (*check all that apply*):

\_\_\_\_\_ gestures

\_\_\_\_\_ phrases

\_\_\_\_\_ sign language (about how many \_\_\_\_\_)

\_\_\_\_\_ sentences

\_\_\_\_\_ words (about how many \_\_\_\_\_)

\_\_\_\_\_ conversation

When did you become concerned about your child's speech?

What do you think may have caused your child to have this difficulty?

Has your child's speech and language become worse or has it gotten better over time?

Is your child self-conscious about his/her speech or language?

Is there any history of speech, language or hearing difficulties in your family? If so, please describe.

Have any other speech-language pathologists seen your child? If so, who and when? What were their conclusions or suggestions? (Please include reports with application.)

Have any other specialists (e.g., psychologists, neurologists, physicians, therapists, special education teachers, audiologists) seen your child? If so, indicate type of specialist, when your child was seen, and any conclusions or suggestions.

Is your child currently receiving any speech-language, physical or occupational therapy? Where?

## PRENATAL AND BIRTH HISTORY

During pregnancy, did the mother experience any unusual illnesses or accidents, or require any medication?

Length of Pregnancy: \_\_\_\_\_ Length of Labor: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Circle type of delivery (Please circle):    Vaginal    Caesarian

Did your child experience any unusual conditions immediately following birth?

Difficulty Breathing \_\_\_\_\_

Feeding/Sucking \_\_\_\_\_

Jaundice \_\_\_\_\_

Reflux \_\_\_\_\_

Muscle Tone \_\_\_\_\_

Choking \_\_\_\_\_

Body Temperature \_\_\_\_\_

Gastrointestinal Problems \_\_\_\_\_

Other \_\_\_\_\_

Please provide more information on any items checked above: \_\_\_\_\_

---



---

## MEDICAL HISTORY

Provide approximate ages at which your child experienced any of the following illnesses or conditions:

Allergies \_\_\_\_\_

Asthma \_\_\_\_\_

Chicken Pox \_\_\_\_\_

Colds \_\_\_\_\_

Croup \_\_\_\_\_

Dizziness \_\_\_\_\_

Draining Ear \_\_\_\_\_

Ear Infections \_\_\_\_\_

Tonsillitis \_\_\_\_\_

Encephalitis \_\_\_\_\_

German Measles \_\_\_\_\_

Influenza \_\_\_\_\_

Headaches \_\_\_\_\_

High Fever \_\_\_\_\_

Seizures \_\_\_\_\_

Mastoiditis \_\_\_\_\_

Measles \_\_\_\_\_

Meningitis \_\_\_\_\_

Mumps \_\_\_\_\_ Pneumonia \_\_\_\_\_ Head Injury \_\_\_\_\_  
 Sinusitis \_\_\_\_\_ Tinnitus \_\_\_\_\_ RSV \_\_\_\_\_  
 Other \_\_\_\_\_

Please provide more information on any items checked above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has your child had any surgeries, accidents or hospitalizations? If so, what type and when?

Does your child have a medical diagnosis (e.g., autism spectrum disorder, cerebral palsy, Down syndrome, hearing loss)? Please specify.

Is your child taking any medications? If so, please list.

Has your child had any negative reactions to medication? Please describe.

Is your child sensitive to latex?

DEVELOPMENTAL HISTORY

Provide the approximate age at which your child began the following activities:

Crawl: \_\_\_\_\_ Sit: \_\_\_\_\_ Stand: \_\_\_\_\_ Walk: \_\_\_\_\_  
 Feed Self: \_\_\_\_\_ Dress Self: \_\_\_\_\_ Use Toilet: \_\_\_\_\_

Has your child ever had a hearing test? Where and When? Provide results.

Does your child consistently respond to sounds (e.g., doorbell, his/her name)?

Does your child seem to have difficulty hearing speech?

Is it difficult for you or others to understand your child's speech?

Are there any specific sounds that you feel your child makes incorrectly?

Does your child have difficulty attending to tasks or play activities? Please describe.

Does your child ever engage in excessive repetition of words or sentences that he/she has heard other people say?

Does your child have difficulty walking, running or participating in activities that require muscle coordination? Please describe.

Are there, or have there ever been, any feeding problems (e.g., difficulty sucking, chewing, swallowing, drooling or coughing during eating)? Please describe.

Does your child have any sensory issues (e.g., sensitivity to sounds/noise, textures, touch)? Please describe.

Does your child have any apparent vision problems?

How does your child interact with others (e.g., aggressive, uncooperative, shy, age appropriate)?

Are there specific things that make your child angry or afraid? Specify.

What are your child’s favorite activities at home?

List any special interests. (e.g., dinosaurs, computer games, TV shows).

Whom does your child spend most of his/her time with?

Does your child have an Individualized Education Plan (IEP) in the school setting?

**Please send a copy of the IEP with this application.**

**Please include any additional reports or information that might be helpful in the evaluation and/or remediation of your child's speech/language problem.**

\*\*In order to be considered for an evaluation or treatment, this form must be completed and submitted in its entirety.

Person completing form: \_\_\_\_\_

Are you the Parent or Legal Guardian? \_\_\_\_\_  
(Circle One)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please note that this form must be signed by a child's parent or legal guardian.**