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

_____ sign language (about how many _____)

_____ words (about how many _____)

_____ phrases

_____ sentences

_____ 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?

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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.

Are your child's immunizations up to date?

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.