Client Case History

Client's Full Name:____
Name by which client is called:____
Date of Birth:___________________________ Age:_________________________
Home Address:____
____
Client's Home Phone Number: ________________ Cell Phone Number: ______________
What language(s) is/are spoken at home?____
What concerns bring you to Speech Language Therapy?
____
____
Have you discussed these concerns with your child's doctor or teacher?
____
____
Child's Doctor:____
Address:_____________________________________ Telephone:___________________
City:_______________________________________ State:_________ Zip:_______
List any medical diagnoses the child has:____
____
____
What do you hope to accomplish by attending Speech Language Therapy?
____
____
Has your child in the past or does he/she currently use an augmentative communication device or any assistive technology at home or at school? Yes_____ No_____
If he/she has used in the past only, briefly explain why he/she is not currently using:____
____
____
Who evaluated your child for the augmentative communication device or assistive technology?
____

FAMILY INFORMATION

Name of Mother:____________________________ Languages Spoken:______________ _
Address:____
Work Phone:_______________________________ Home Phone:_____________________
Cell Phone:_______________________________ E-Mail:_________________________

Name of Father:____________________________ Languages Spoken:________________

Address:____

Work Phone:_______________________________ Home Phone:_____________________

Cell Phone:________________________________ E-Mail:_________________________

With whom does your child live? (List in table below)

Name	Age	Gender	Speech Problem	Remarks

COMMUNICATION STATUS

How would you describe the client's current communication ability? (Check all that apply.)

______Almost never communicates

______Sometimes communicates

______Communicates frequently

______Is very easy for me to understand when I know the topic of conversation

______Is fairly easy for me to understand when I know the topic of conversation

______Is difficult for me to understand when I know the topic of conversation

______Is very easy for me to understand if I don't know the topic of conversation

______Is fairly easy for me to understand if I don't know the topic of conversation

______Is difficult for me to understand if I don't know the topic of conversation

______Is usually understood by other people who don't know him/her well

______Is usually NOT understood by other people who don't know him/her well

In your own words, please describe how your child communicates:

____

____

____

Indicate the extent to which you agree with the following statements (circle one):

Your child is able to communicate effectively to express pleasure or displeasure.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

Your child can communicate to get help when needed.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

Your child's biggest communication need is to ask for things he/she needs.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

Your child's biggest communication priority is to get or give information (e.g., ask or answer questions).

Strongly Disagree Disagree Not Sure Agree Strongly Agree

What words, if any, does your child say?

____

____

What words, if any, does your child write?

____

____

____

What gestures does your child make (e.g. pointing, motioning to "come here", and tugging for attention)? When does he/she use these gestures?

____

____

____

Briefly describe a typical day for your child:

____

____

____

____

Please list any of your child's achievements that are especially important to him/her or you:

____

____

What manual signs (or sign language) does your child use? When does he/she use these signs?

____

____

____

What other things does he/she do to communicate (e.g., Look at something he/she wants, blinks eyes)?

____

____

____

____

THERAPEUTIC INFORMATION

Please list some things your child really likes and dislikes e.g., food, shows, toys:

____

____

____

____

Please list any special interests or hobbies your child has:

____

____

____

____

PRENATAL AND BIRTH HISTORY

Check any of the factors below that apply for the Client's Birth Mother:

During Pregnancy

____Excessive vomiting

____Hemorrhaging

____X-ray treatments

____Illnesses (i.e., German measles

____Medications

____RH incompatibility

____Drug use

____Smoking

____Previous miscarriages

____Alcohol use

____Trauma/injuries

____High blood pressure

____Excessive weight loss

____Excessive weight gain

____Diabetes

____Premature rupture of

____Need for hospitalization

____Membranes or bed rest

	Age	Mild	Moderate	Severe		Age	Mild	Moderate	Severe
Allergies					Heart Problems				
Asthma					Meningitis				
Convulsions/ Seizures					Muscle Disorders				
Dental Problems					Nerve Disorders				
Encephalitis					Pneumonia				
Headaches					Vision Problems				
Head Injuries									
Ear Infections									

Describe any other illnesses, accidents, injuries, operations, and hospitalizations:

____

____

____

Does your child use a wheelchair or assistive walking device?

____

SPEECH AND LANGUAGE DEVELOPMENT

Indicate when your child first demonstrated the following:

Age	Behavior	Age	Behavior
____	Cooing, pleasure sounds	____	Single words
____	Babbling (ba-ba, da-da, etc.)	____	Phrases (go bye-bye, more juice
____	Jargon (talking own special language	____	Short sentences

What is the primary method(s) your child uses for letting you know what he/she wants?

____ Looking at objects

____ Pointing at objects

____ Gestures

____ Crying

____ Vocalizing/grunting

____ Physical manipulation

____ Single words

____ 2-3 word combinations

____ Sentences

Which of the following best describes your child's speech?

____ Easy to understand

____ Difficult for parents to understand

____ Difficult for others to understand

____ Almost never understood by others

____ Different from other children of the same age

Which of the following statements best describes your child's reaction to his/her speech?

____ Is easily frustrated when not understood

____ Does not seem aware of speech/communication problem

____ Has been teased about his/her speech

____ Tries to say sounds or words more clearly when asked

____ Is successful in saying sounds or words more clearly when he/she tries

Is your child aware of his/her communication difficulties?

____Yes ____No

If “yes”, how does this awareness impact your child’s social/emotional status?

____

Does your child have difficulty producing certain sounds?

____Yes ____No

If “yes,” which ones?____

Does your child hesitate and/or repeat sounds or words?

____Yes ____No

Does your child “get stuck” when attempting to say a word?

____Yes ____No

Do you have concerns about your child’s voice?

____Yes ____No

Which of the following do you think your child understands?

____His/her own name ____Names of objects ____Conversational speech

____Names of body parts ____Simple directions

____Family names ____Complex directions

MOTOR DEVELOPMENT

At approximately what age did your child achieve the following motor milestones?

Head support ______ Standing alone______ Eat with a spoon______

Reach & grasp______ Walking alone ______ Potty trained ______

Sitting alone ______ Climbing stairs______ Undressed self ______

Crawling ______ Finger foods ______

Is your child overly awkward or clumsy?

____Yes ____No

Does your child display a hand preference?

____Yes ____No

If “yes”, which hand does your child prefer to use?

____Right ____Left

Has your child had any feeding difficulties? Check each item that applies.

____Sucking or nursing

____Excessive length of time to drink bottle

____Regurgitation of liquids or solids through the nose

____Difficulty chewing or swallowing meats

____Chocking and/or gagging

Does your child choke while eating? ____Yes ____No

If "yes", on what foods?

____

Is your child a picky eater? ____Yes ____No

If "yes", what foods does he/she prefer?

____

Describe any feeding problems your child experienced during the first three months of life:

____

____

Does your child drool more than other children his/her age? ____Yes ____No

Did your child have difficulty gaining weight as an infant? ____Yes ____No

Does/Did your child use a pacifier? ____Yes ____No

Does/Did your child suck their thumb? ____Yes ____No

Check any of these as they apply to your child:

	Yes	No	If yes,explain and give ages if possible
Eating problems			
Sleeping problems			
Toileting problems			
Difficulty concentrating			

Needs a lot of structure			
Interactive			
Excitable			
Laughs easily			
Cries a lot			
Difficult to manage			
Overactive			
Sensitive			
Personality problems			
Gets along with others			
Emotional			
Stays with an activity			
Makes friends easily			
Happy			
Irritable			

PLAY BEHAVIORS

Which of the following describes the type of play your child likes to engage in the most often?

____Putting toys in mouth ____Banging toys together ____Throwing toys

____Shaking toys ____Pushing/pulling toys ____Role-playing

____Uses one object for another ____Games with rules ____Rough & tumble play

____Appropriate use of objects ____Make believe play ____Looking at books

____Acting out familiar routines

What is the average length of time your child can stay playing at one activity?

____

Which activities seem to hold your child's attention for the longest period of time?

____

____

Which activities seem to hold your child's attention for the shortest period of time?

____

____

Is your child's play easily distracted by any of the following?

____Visual stimuli (i.e., other toys or objects)

____Auditory stimuli (i.e., voices, sounds outside, the TV)

____Nearby activities

____Other people in the room

Whom does your child prefer to play with? (Circle all that apply.)

Mother **Father** **Brother/Sister** **Self** **Other Child** **Other Adult**

List some of your child's favorite toys, TV programs and videos:________________________

____

____

SOCIAL/EMOTIONAL DEVELOPMENT

Check behaviors that you feel best describes your child:

____Overly active

____Overly quiet

____Excessive tantrums

____Destructive

____Very shy

____Perfectionistic

____Friendly, outgoing

____Imaginative and creative

____Plays well with other children

____Defiant

____Easily controlled/Passive

____Nervous

____Dependent upon routines

____Difficulty separating from parent

____Thumb-sucking

____Drooling

____Teeth grinding

____Mouth breather

____Prefers older children ____Interrupted/Unusual eating habits
____Prefers younger children ____Interrupted/Unusual sleeping habits

Describe any discipline problems you have with your child:

____

____

Describe any evaluations or therapy for behavior or emotional problems:

____

____

What method of discipline do you use?____

What method of discipline does your spouse use?_____________________________________

EDUCATIONAL HISTORY

Educational Setting	Location/School	Teacher(s)
Child Care Facility		
Early Childhood Classes		
Birth to Three programs		

How often does your child attend classes?

____Daily ____4 Times per week ____3 Times per week

____2 Times per week ____1/2 Days ____Full day

How many children are in your child's class?____

What type of classroom is your child in? (i.e., traditional, open classroom, transdisciplinary, etc.)

____

____

Does your child exhibit any learning style preferences? ___Visual ___Auditory ___Both

Does your child's developmental performance seem to interfere with his/her school

performance?

____Yes ____No

If “yes”, please explain:____

____

____

Have teachers expressed any concerns about your child’s learning behavior?

____Yes ____No

If “yes”, please describe:____

____

____

Has your child ever been evaluated for or attended therapy for:

____Speech problems ____Vision problems ____Feeding problems

____Hearing problems ____Physical motor problems

____Other ____

Please give locations, dates, and results:

____

____

____

What other services does your child have now? What has he/she had in the past?

Type of Service	Has Now	Had Before
Physical Therapy		
Speech-Language Therapy		
Occupational Therapy		
Psychological or Behavioral Counseling		
Nutrition		
Other (describe)		

HEARING HISTORY

Does your child have a history have a history of ear infections or otitis media?

____Yes ____No

How many occurrences of ear problems?____

At what age?____________________ Age of onset?_____________________________

How long did each ear problem last?____

What treatments (medications) were prescribed?_____________________________________

____

Has your child ever been treated by an ear, nose, throat specialist? ____Yes ____No

Who?______________________________ When?____________________________

Does your child say “huh” or “what” at least five or more times a day? ____Yes ____No

Do you ever question your child’s ability to hear normally? ____Yes ____No

If “yes”, please explain:____

____

Is your child easily distracted? ____Yes ____No

Does your child have difficulty following directions? ____Yes ____No

When was the last time your child’s hearing was checked?

____Within the last year ____1-3 years ago ____ 4 or more years ago