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?____

Who referred you to SPEECH PATHways?____

What concerns bring you to SPEECH PATHways?______________________________________

____

Have you discussed these concerns with your child's doctor or teacher?____________________

____

List any medical diagnoses the child has:____

____

____

What do you hope to accomplish by coming to Speech PATHways?_______________________

____

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:____

Occupation:________________________________ Education Level:___________________

Work Phone:_______________________________ Home Phone:______________________

Cell Phone:________________________________ E-Mail:___________________________

Name of Father:_____________________________ Languages Spoken:_________________

Address:____

Occupation:________________________________ Education Level:__________________

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)?

____

____

____

____

THERAPUTIC INFORMATION

Please list some things your child really likes and dislikes:

FOODS		**PEOPLE**		**TV SHOWS**	
Likes	Dislikes	Likes	Dislikes	Likes	Dislikes

PLACES		THINGS TO DO		OTHER	
Likes	Dislikes	Likes	Dislikes	Likes	Dislikes

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
____Illnesses (i.e., German measles)
____Drug use
____Alcohol use
____Excessive weight loss
____Premature rupture of membranes
____Hemorrhaging
____Medications
____Smoking
____Trauma/injuries
____Excessive weight gain
____Need for hospitalization or bed rest
____X-ray treatments
____RH incompatibility
____Previous miscarriages
____High blood pressure
____Diabetes

CLIENT'S MEDICAL HISTORY

For any conditions that apply, provide age of onset and check if condition is mild, moderate or severe.

	Age	Mild	Mod	Severe		Age	Mild	Mod	Severe
Allergies					Heart Problems				
Asthma					Meningitis				
Convulsions / Seizures					Muscle Disorder				
Dental Problems					Nerve Disorder				
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 body parts	____Family names
____Names of objects	____Simple directions	____Complex directions
____Conversational speech		

MOTOR DEVELOPMENT

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

Head support ______	Reach & grasp______	Sitting alone ______
Crawling ______	Standing alone______	Walking alone ______
Climbing stairs______	Finger foods ______	Eat with a spoon______
Potty trained ______	Undressed self ______	

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 & 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
____Shaking toys
____Uses one object for another
____Appropriate use of objects
____Acting out familiar routines
____Banging toys together
____Pushing/pulling toys
____Games with rules
____Make believe play
____Throwing toys
____Role-playing
____Rough & tumble play
____Looking at books

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
____Prefers older children
____Prefers younger children

____Defiant
____Easily controlled/Passive
____Nervous
____Dependent upon routines
____Difficulty separating from parent
____Thumb-sucking
____Drooling
____Teeth grinding
____Mouth breather
____Interrupted/Unusual eating habits
____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 3 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		
Occupational Therapy		
Speech-Language Therapy		
Psychological or Behavioral Counseling		
Nutritional Services		
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

INSURANCE INFORMATION

Do you have insurance? ____Yes ____No

If "yes,"provide company name:____

Policy Number:____

Does your insurance cover speech-language evaluations?____Yes ____No

Does your insurance cover speech-language therapy? ____Yes ____No

Is your insurance a HMO? ___ Yes ___No

Is your insurance a PPO? ___Yes ___No

Who is responsible for your child?____

Relationship?____

Child's Doctor:____

Address:_______________________________________ Telephone:____________________

City:____ State:__________ Zip:________