CHI St. Joseph Health

Child Case History
Speech Therapy Department

Family Information:

Child's Name:_____ Sex: M / F
Father's Name:_____ Daytime Phone: _____
Address:_____ Cell Phone: _____
_____ E-mail: _____
_____

Mother's Name:_____ Daytime Phone: _____
Address:_____ Cell Phone: _____
_____ E-mail: _____
_____

Doctor's Name:_____ Doctor's Phone: _____
Birth date: _____

Child lives with (check one):

☐ Birth Parents ☐ Foster Parents ☐ One Parent
☐ Adoptive Parents ☐ Parent and Step-Parent ☐ Other _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Are there any other speech, language or hearing problems in your family? If so, please explain:

_____
_____
_____

Child's race/ethnic group: _____

What languages are spoken at home? _____
Who speaks them in your family?_____
Which are spoken by your child? _____
Which are understood by your child? _____
Which language does your child prefer to speak at home? _____
What percentage of English is spoken by your child? _____
When was your child first exposed to English? _____

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Speech-Language-Hearing:
Do you feel your child has a speech problem? Y / N
If yes, please describe.

_____
_____
_____

Do you feel your child has a hearing problem? Y / N
If yes, please describe.

_____
_____
_____

Has your child ever had a speech evaluation/screening? Y / N
If yes, please describe.

_____
_____
_____

Has your child ever had a hearing evaluation/screening? Y / N
If yes, please describe.

_____
_____
_____

Has your child ever had speech therapy? Y / N
If yes, where and when? _____
What was he/she working on? _____
_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? Y / N
If yes, please describe. _____
_____
_____

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? _____
_____

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Educational History:

Preschool Age:
Educational Setting: ↑Child Care Facility ↑Early Childhood Classes
↑Birth to 3 Program ↑Home

How often does your child attend classes?
_____ daily _____ 4 times per week _____ 3 times per week
_____ 2 times per week _____ ½ days _____ full day

Does your child's developmental performance seem to interfere with his/her school performance? _____ Yes _____ No

Have teachers expressed any concerns about your child's learning behavior?
_____ Yes _____ No
If so please describe.
_____

School Age:
Name of School: _____Grade: _____
Teacher's Name: _____
Has your child repeated a grade?: Y / N Reason: _____
What are your child's strengths and/or best subjects? _____
_____
Is your child having difficulty with any subjects? _____
Is your child receiving help in any subjects? _____
_____

Birth History:
Was there anything unusual about the pregnancy or birth? Y / N
If yes, please describe: _____
_____
_____
How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? Y / N
If yes, please describe: _____
_____

Length of pregnancy?_____

Did the child go home with his/her mother from the hospital? Y / N
If the child stayed at the hospital, please describe why and how long.
_____
_____

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Medical History:

Has your child had any of the following?

- ☐ adenoidectomy
- ☐ allergies
- ☐ breathing difficulties
- ☐ chicken pox
- ☐ colds
- ☐ dental problems
- ☐ ear infections
  How often?
  _____
- ☐ ear tubes
- ☐ encephalitis
- ☐ flu
- ☐ gastrointestinal problems
- ☐ head injury
- ☐ high fevers
- ☐ measles
- ☐ meningitis
- ☐ mumps
- ☐ respiratory problems
- ☐ scarlet fever
- ☐ seizures
- ☐ sinusitis
- ☐ sleeping difficulties
- ☐ thumb/finger sucking habit
- ☐ tongue-tied
  Clipped? Y / N
- ☐ tonsillectomy
- ☐ tonsillitis
- ☐ vision problems

Other serious injuries/surgeries:

_____

Is your child currently (or recently) under a physician's care? Y / N

If yes, why? _____

_____

Please list any medications your child takes regularly: _____

_____

_____

Developmental History:

Please indicate the approximate age your child achieved the following developmental milestones:

_____ sat alone
_____ crawled
_____ stood
_____ walked
_____ fed self
_____ dressed self
_____ used toilet
_____ grasped crayon/pencil
_____ babbled
_____ said first words
_____ used requests
_____ used labels
_____ put two words together
_____ named simple objects
_____ used simple sentences

Does your child do any of the following?

- ☐ have difficulty sucking? _____
- ☐ have difficulty chewing? _____
- ☐ have difficulty swallowing? _____
- ☐ choke on food or liquids? _____
- ☐ picky eater with certain textures and/or foods?_____
- ☐ drool? _____
- ☐ currently put toys/objects in his/her mouth? _____
- ☐ brush his/her teeth and/or allow brushing? _____

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Current Speech-Language-Hearing

Your child currently communicates using (check all that apply)…

- ☐ body language/gestures
- ☐ crying
- ☐ sounds (vowels, grunting)
- ☐ single words
- ☐ physical manipulation
- ☐ 2 to 4 word sentences
- ☐ sentences longer than 4 words
- ☐ other _____

Does your child (check all that apply)…

- ☐ repeat sounds, words or phrases over and over?
- ☐ understand what you are saying?
- ☐ retrieve/point to common objects upon request (ball, cup, shoe)?
- ☐ follow simple directions (“shut the door” or “get your shoes”)?
- ☐ respond correctly to yes/no questions?
- ☐ respond correctly to who/what/where/when/why questions

Behavioral Characteristics (check all that apply)

- ☐ cooperative
- ☐ attentive
- ☐ willing to try new activities
- ☐ plays alone for a reasonable amount of time
- ☐ separation difficulties
- ☐ easily frustrated/impulsive
- ☐ strong-willed
- ☐ restless
- ☐ poor eye contact
- ☐ easily distracted/short attention
- ☐ destructive/aggressive
- ☐ withdrawn
- ☐ inappropriate behavior
- ☐ self-abusive behavior

Play Behaviors (check all that apply)…

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
- ☐ inattentive to toys
- ☐ appropriate use of objects
- ☐ uses one object for another
- ☐ acting out familiar routines
- ☐ role-playing
- ☐ make believe play
- ☐ games with rules
- ☐ rough and tumble play
- ☐ looking at books
- ☐ playing with others
- ☐ playing by self
- ☐ taking turns
- ☐ playing with toys in repetitive manner (spinning/lining up items, etc)
- ☐ other: _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____

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Please provide us with any additional information, which may be helpful for treatment:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Does CHI St. Joseph Health Rehabilitation Center have your permission to contact teachers, therapists, or other professionals by phone regarding your child's progress? Y / N

Form completed by:

_____

Relationship to child:

_____

Signature:

_____

Date:

_____