Anna's Speech & Language Therapy

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Anna's Speech And Language Services
CASE HISTORY FORM

Identifying: Child's Name: _____

Date of Birth: _____ Gender: ___M ___ F

Father's Name: _____

Address: _____ Mobile Phone: _____

E-mail: _____

Mother's Name: _____

Address: _____ Mobile Phone: _____

E-mail: _____

Preferred method of contact: E-mail _____

Preferred method of contact: Phone _____

Doctor's Name: _____ Doctor's Phone: _____

Other Medical Professionals Involved: _____

_____

_____

Preferred contact method Email or
Phone:_____

_____

Child lives with (Tick one):

___ Birth Parents

___ Foster Parents: - Include dates_____

___One Parent_____

___ Adoptive Parents_____

Parent and Step-Parent_____

Other:- Please describe _____

Other children in the family:

Name
Age
Gender
Speech/language and or Hearing or ear, nose and or throat ENT issues:-

_____
_____
_____
_____
_____
_____

Are there any relatives that have a history of speech-language-hearing or ENT difficulties?

___Mother: If yes, please describe. _____
_____
___Father: If yes, please describe. _____
_____
___Aunts: If yes, please describe. _____
___Uncles: If yes, please describe. _____
___Cousins: If yes, please describe. _____
___Grandparents: If yes, please describe. _____

Child's ethnic group: _____

Is there a language other than English spoken in the home? ____ Yes ____ No
If yes, which one?_____
Does the child speak the language? ____ Yes ____ No
Does the child understand the language? ____ Yes ____ No
Who speaks the language? _____
Which language does the child prefer to speak at home? _____
How long has the child been speaking his/her first language? _____
How long has the child been speaking English? _____

Name of School: _____
Year: _____ Teacher's Name: _____
Senco _____Email:_____

Speech-Language-Hearing-ENT

Do you feel your child has a speech problem? ____ Yes ____ No
If yes, please describe. _____
_____

Do you feel your child has a hearing problem? ____ Yes ____No
If yes, please describe. _____
Has he/she ever had a hearing test? ____ Yes ____ No
If yes, where and when? _____
What were you told? _____
_____
Has he/she ever had a speech-language assessment? ____ Yes ____ No
If yes, where and when? _____
_____
What were you told? _____
_____
Has your child ever had speech therapy? ____ Yes ____ No
If yes, where and when?_____

What was he/she working on?_____
_____
Has your child received any other assessments or therapy (physiotherapy, counselling, occupational therapy, etc.)? _____ Yes ____ No
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?_____
_____

Birth History

Was there anything unusual about the pregnancy or birth? ___ Yes ___ No
If yes, please describe. _____

_____

Was the mother sick during the pregnancy? ___ Yes ___ No

If yes, please describe. _____

_____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ____ Yes ____ No

If child stayed at the hospital, please describe why and how long. _____

_____

Medical History

Has your child had any of the following?

____adenoidectomy	____ encephalitis	____ seizures
____ allergies	____ flu	____ sinusitis
____ breathing difficulties	____ head injury	____ sleeping difficulties
____ chicken pox	____ high fevers	____ thumb/finger sucking habit
____ colds	____ measles	____ tonsillectomy
____ mumps	____ meningitis	____ tonsillitis
____ vision problems		____ ear tubes
	____ ear infections	____stroke

How often? _____

Describe any major accidents / injuries, surgeries or hospitalizations: _____

_____

Does your child have any medical diagnoses? ADD, ADHD, PDA, Anxiety, Autism, Dyslexia, Dyspraxia, Down Syndrome?

_____

_____

Others please describe:

_____

Is your child currently (or recently) under a physician's care? ___ Yes ___ No

If yes, why? _____

Please list any medications your child takes regularly: _____

_____

Please list any known allergies: _____

Developmental History

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

_____ sat alone
_____ babbled
_____ put two words together
_____ walked
_____ grasped crayon/pencil
_____ said first words
_____ spoke in short sentences
_____ toilet trained

Does your child: (please tick)

____ **Yes** ____ **No** Choke on food or liquids?
____ **Yes** ____ **No** Currently put toys/objects in his/her mouth?
____ **Yes** ____ **No** Brush his/her teeth and/or allow brushing?

Please describe your child's gross motor skills (coordinated, clumsy, falls a lot, slow, etc.) while walking, running, climbing, riding bikes, roller skating, etc. _____
_____

Please describe your child's fine motor skills while attempting to colour, write, draw, cut with scissors, feed him/herself with utensils, etc.
_____
_____

Indicate with a tick any items that are difficult for you child:

____ Blowing bubbles
____ Following directions or routines
____ Understanding concepts (size, shape)
____ Asking questions
____ Recognizing “common” words
____ Speaking in organized sentences
____ Describing objects
____ Rhyming
____ Using a straw
____ Understanding what he/she hears
____ Understanding concept of time
____ Answering questions
____ Thinking of words for things
____ Using correct grammar
____ Telling stories
____ Saying sounds of letters

Current Speech-Language-Hearing

Does your child...

___ Yes ___ No Repeat sounds, words or phrases over and over?
___ Yes ___ No Understand what you are saying?
___ Yes ___ No bring to you or point to common objects upon request (ball, cup, shoe)?
___ Yes ___ No Point to common objects upon request (pass me a tissue, Where’s your cup etc.)

___ Yes ___ No Follow simple directions (“Shut the door” or “Get your shoes”)?
___ Yes ___ No Respond correctly to yes/no questions?
___ Yes ___ No Respond correctly to the following questions:-

Please tick and include examples if you can-
Who_____

What_____

Where_____

When_____

Why_____

Your child currently communicates using...
____ body language.
____ sounds (vowels, grunting).
____ words (shoe, doggy, up).
____ 2 to 4 word sentences.
____ sentences longer than four words.
____ other _____

Speech Sounds:
___ Yes ___ No Can you understand what your child is saying?

___ Yes ___ No Do people outside of the home find it difficult to understand your child?

Fluency:
___ Yes ___ No Does your child ever repeat initial sounds many times (e.g.: m-m-m-mmum?)

___ Yes ___ No Does your child ever repeat syllables many times (e.g.: “bu-bu-bu-bububbles?”)

___ Yes ___ No Does your child ever prolong sounds and have difficulty moving from that sound to the remaining sounds in the word (e.g. “ssssssave me a seat”)

___ Yes ___ No Does your child ever show physical tension or struggle when they are talking?

Social Pragmatics:
___ Yes ___ No Does your child play with other children?

___ Yes ___ No Can your child have a back and forth conversation with you or friends or siblings?

___ Yes ___ No Getting his/her point across?

___ Yes ___ No Beginning a conversation

___ Yes ___ No Staying on topic

___ Yes ___ No Interpret body language

___ Yes ___ No Understand/respond to facial expression

How does your child interact with others? ___ Friendly ___ Quiet ___ Aggressive

Other: please describe _____

Behavioral Characteristics (please tick):-

___ Yes ___ No Cooperative
___ Yes ___ No Attentive
___ Yes ___ No Willing to try new activities
___ Yes ___ No Withdrawn
___ Yes ___ No Easily frustrated/impulsive
___ Yes ___ No Self-abusive behaviour
___ Yes ___ No Plays alone for reasonable length of time
___ Yes ___ No Easily distracted/short attention
___ Yes ___ No Restless
___ Yes ___ No Poor eye contact
___ Yes ___ No Destructive/aggressive
___ Yes ___ No Separation difficulties
___ Yes ___ No Stubborn
___ Yes ___ No Inappropriate behaviour

School History

Has your child repeated a year? _____

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? _____

_____

Please describe any special input your child is receiving? _____

_____

Does he/she have an Individual Education Plan (IEP)? _____

_____

Please include a copy

Additional Comments - anything you think has not been asked and you feel it is important that we know.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Person completing form: _____ Date competed : _____

Relationship to child: _____

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