AGAPE SPEECH THERAPY, LLC

SPEECH AND LANGUAGE CASE HISTORY FORM

Identifying and Family Information:

Child's Name: ___________________________________ Birthdate: _____/_____/_____ 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: (   )   -

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

Child's race/ethnic group:

☐ Caucasian, Non-Hispanic ☐ Hispanic ☐ African-American

☐ Native American ☐ Asian or Pacific Islander ☐ Other ____________

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? ___________________________

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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 speech evaluation/screening? Yes ☐ No ☐

If yes, where and when? ____

What were you told? ____

____

____

Has he/she ever had a hearing evaluation/screening? 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 evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? Yes ☐ No ☐

If yes, please describe.____

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Is your child aware of, or frustrated by, any speech/language difficulties?________________________________

____

What do you see as your child's most difficult problems in the home? ________________________________

____

____

What do you see as your child's most difficult problems in school?________________________________

____

____

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BIRTH HISTORY

Was there anything unusual about the pregnancy or birth? Yes ☐ No ☐

If yes, please describe. ____

____

____

How old was the mother when the child was born? _______________

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?

	Yes	No		Yes	No		Yes	No
adenoidectomy	☐	☐	seizures	☐	☐	high fevers	☐	☐
allergies	☐	☐	flu	☐	☐	head injury	☐	☐
breathing difficulties	☐	☐	meningitis	☐	☐	vision problems	☐	☐
chicken pox	☐	☐	colds	☐	☐	sleeping difficulties	☐	☐
encephalitis	☐	☐	measles	☐	☐	tonsillectomy	☐	☐
ear infections	☐	☐	tonsillitis	☐	☐	→ How often?________________		
ear tubes	☐	☐	mumps	☐	☐	thumb/finger sucking	☐	☐
scarlet fever	☐	☐	sinusitis	☐	☐			

Other serious injury/surgery: ____

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

If yes, why?____

____

Please list any medications your child takes regularly: ____

____

____

____

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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...	**Yes**	**No**
choke on food or liquids?	☐	☐
currently puts toy/object in his/her mouth?	☐	☐
brush his/her teeth and/or allow brushing?	☐	☐

CURRENT SPEECH-LANGUAGE-HEARING

Does your child...	**Yes**	**No**
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?	☐	☐

Your child currently communicates using...

body language	**Yes**	**No**
sounds (vowels, grunting)	☐	☐
words (shoe, doggy, up)	☐	☐
2 to 4 word sentences	☐	☐
sentences longer than four words	☐	☐

other ________________________________

Behavioral Characteristics:	**Yes**	**No**		**Yes**	**No**
cooperative	☐	☐	willing to try new activities	☐	☐
attentive	☐	☐	destructive/aggressive	☐	☐
restless	☐	☐	easily distracted/short attention	☐	☐
poor eye contact	☐	☐	plays alone for reasonable length of time	☐	☐
withdrawn	☐	☐	separation difficulties	☐	☐
self-abusive behavior	☐	☐	inappropriate behavior	☐	☐
stubborn	☐	☐	easily frustrated/impulsive	☐	☐

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SCHOOL HISTORY

If your child is in school, please answer the following:

Name of school and grade in school: ____

____

Teacher's name: ____

____

Has your child repeated a grade? ____

____

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? ___________________________________

____

ADDITIONAL COMMENTS

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