



75 West Commercial Street, Suite 205
 Portland, Maine 04101
 Voice/TTY: 207/874-1065
 Fax: 207/874-1068

CHILD CASE HISTORY FORM

Date: _____

Child's Name: _____ **Date of Birth:** _____ Male Female
Home Address: _____
Home Phone #: _____
Form Completed by: Mother Father Guardian Caregiver Other: _____

Family Information:

Parent/Guardian: _____ **Age:** _____ **Occupation:** _____
Address: _____ **Alt. Phone #:** (w) _____ (c) _____
Parent/Guardian: _____ **Age:** _____ **Occupation:** _____
Address: _____ **Alt. Phone #:** (w) _____ (c) _____

Statement of Problem:

Describe the concerns you have about the child's communication skills at this time: _____

What do you think may have caused the difficulties this child is experiencing? _____

When was the problem first noticed? Please specify date and person(s): _____

Are there any skills the child had learned previously, but can no longer use? _____

Has the child's hearing been tested? Yes No If yes, please bring a copy of the hearing test results to your appt.
 If yes, where was the test completed? _____ Date Completed? _____

Results of the hearing test: Hearing within normal limits Hearing loss Further testing required

Family Background:

Name(s) of Others Living With Child	Relationship to Child	Age	Sex

Have any family members had any speech, language, hearing problems, or learning difficulties?
 No Yes If Yes, who? _____ Please describe: _____

What languages are spoken in the home? _____

What is the primary language used with this child? _____

Was this child adopted? No Yes If Yes, at what age? _____ From Where? _____

Child's Medical History:

Name of Child's Physician: _____ Medical Office: _____

Describe the mother's health during pregnancy: Good Fair Poor

Were there any unusual conditions or problems during the pregnancy or birth? No Yes If yes, please describe:

Were there any drugs or alcohol consumed during the pregnancy? No Yes If yes, what and how often?

Was the pregnancy full term? Yes No If no, how early or late? _____

General condition: _____ Birth weight: _____

Does your child have any medically diagnosed illness or conditions? Yes No If yes, please explain:

Is your child taking any medications? Yes No If yes, please list: _____

Has your child experienced any of the following?

- Frequent Colds Seizures Snoring Mouth Breathing Sleeping Problems
 Frequent Ear Infections Other: _____

Has your child had any surgeries, accidents or hospitalizations? No Yes If yes, please explain:

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)? No Yes If yes, please explain: _____

Is there anything else we should know about your child's medical history? Yes No If yes, please explain:

Has your child had any of the following evaluations or assessments? Please indicate:

- Hearing Speech and Language Psychological Physical Therapy
 Neurological Occupational Therapy Developmental Vision

What were the results? _____

Has your child received any of the following services? Speech/Language OT PT Nursing

Please be sure to bring copies of any evaluations, treatment plans, or IEPs, etc.

Developmental History:

Please provide the approximate age at which the child acquired the following skills. If you can't remember the age, check the box that best describes when he/she acquired the skill as compared to his/her peers.

Activity	Age	Earlier than Peers	Same Time as Peers	Later than Peers
Sit				
Crawl				
Roll over				
Walk				
Walk up/down stairs				
Feed self				
Dress self				
Use toilet				

How would you describe your child's motor development (running, skipping, grasping crayons/pencils) as compared to his/her peers? _____

Speech & Language History:

Please provide the approximate age at which the child acquired the following skills. If you can't remember the age, check the box that best describes when he/she acquired the skill as compared to his/her peers.

Activity	Age	Earlier than Peers	Same Time as Peers	Later than Peers
Babbling (e.g., "ba, ba")				
Use first words				
Put 2-3 words together				
Make sentences				
Put sentences together				
Engage in conversation				
Understand directions				

How does your child usually communicate (check all that apply)?

- gestures single words short phrases sentences

In what situations does the child have more difficulty communicating?

- At Home At Daycare/Preschool At School With Friends Everywhere

Has the problem changed since it was first noticed? _____

Approximately how much of your child's speech do you understand?

_____ Less than 10% _____ 25% _____ 50% _____ 75% _____ 90% - 100%

Approximately how much of your child's speech do those less familiar with the child understand?

_____ Less than 10% _____ 25% _____ 50% _____ 75% _____ 90% - 100%

Behavior History:

Often Sometimes Never

	Often	Sometimes	Never
Does your child seem unusually quiet?			
Does your child seem to be restless or fidgety?			
Does your child get upset easily?			
Does your child rock his/her body?			
Does your child enjoy "messy" play?			
Does your child bump or push others?			
Does your child pinch, bite or hurt oneself?			
Does your child have a difficult time with change?			
Is your child easily distracted?			
Does your child understand personal safety?			
Does your child enjoy the company of other children?			
Does your child enjoy reading or having books read to him/her?			

Describe your child: (Check all that apply)

- Friendly Shy Cooperative Independent
 Stubborn Difficult to handle Other _____

Do you have any concerns about your child's behavior? If so, please describe:

Educational History:

Is your child currently attending:

- Day care Preschool Head Start Where: _____

Number of hours per week: _____ How is your child doing in the program? _____

Does your child receive any special services at school? If yes, please describe: _____

How does your child interact with others (e.g., friendly, shy, cooperative, etc.)? _____

Do you have any concerns about your child's behaviors at school? If so, please describe: _____

Additional Information:

What changes would you like to see in your child's development within the next year? _____

What do you see as your child's strengths? _____

What does your child enjoy playing with or enjoy doing? _____

Is there a teacher or caregiver who we may contact to gather further information about your child? If yes, please identify:

Name: _____ Position: _____ Telephone: _____

Name: _____ Position: _____ Telephone: _____

Name: _____ Position: _____ Telephone: _____

I authorize Northeast Hearing & Speech staff to contact the above person(s), as needed for the purpose of gathering information for my child's evaluation.

Parent/Guardian signature