Northeast Hearing & Speech
hear • speak • communicate

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SCHOOL-AGED CHILD CASE HISTORY FORM

Date: _____

Child's Name: _____ Date of Birth: _____

Completed By: _____

Relationship to Child: _____

Address: _____

_____

Home Phone: _____

Business Phone: _____

Mother's Name: _____

Place of Employment: _____

Father's Name: _____

Place of Employment: _____

FAMILY:

Person's living in Child's Home	Relationship to Child	Sex	Age

Please describe any serious health, learning, speech and language, and/or hearing problems in the family:

_____

_____

_____

Name of school child attends: _____

School District: _____

Teacher's Name: _____

Grade: _____

CHILD'S DOCTOR(S):

Name	Town	Specialty	Date Last Seen

Other agencies involved with this child (please include after school activities):

Name	Town

CHILD'S MEDICAL HISTORY:

Were there any problems during pregnancy with this child? If yes, please describe:

_____

_____

Were there any problems during birth or immediately after? If yes, please describe:

_____

_____

Birth Weight: _____

How long did this child stay in the hospital after birth? _____

List any medically diagnosed illnesses or conditions: _____

_____

_____

_____

List any serious accidents:

Incident Approximate age of child

_____

_____

_____

Do you notice, or has a doctor reported, any of the following:

_____ Asthma _____ Headaches _____ Eating problems

_____ Allergies _____ Overtired/lacking energy _____ Seizures

_____ Frequent colds _____ Sleeping problems _____ Frequent high fevers

_____ Mouth breathing

Please list medications presently being taken by this child and reasons for taking them:

_____

_____

Has this child had an evaluation in any of the following areas?

_____ Hearing _____ Vision _____ Physical Therapy

_____ Speech/language _____ Psychological _____ Occupational Therapy

_____ Developmental _____ Neurological _____ Other _____

CHILD'S DEVELOPMENTAL HISTORY:

Has this child ever had problems learning/doing the following:

_____ Sitting _____ Crawling _____ Walking _____ Running

_____ Eating _____ Toileting _____ Dressing _____ Writing

_____ Chewing/Swallowing _____ Climbing Stairs _____ Picking up objects

If so, please describe: _____

_____

_____

_____

HEARING AND SPEECH/LANGUAGE HISTORY:

How many ear infections has this child had?_____

When did the last ear infection occur?_____

How were the ear infections treated?_____

By whom? _____

Has this child ever had tubes? If so, when? _____

Does this child have them now? _____

Are you concerned about this child's ability to hear? If so, explain: _____

_____

Has this child had a hearing evaluation? If so, when, where, and what were the results? _____

_____

_____

Describe any problems/delays this child may have had learning to:

Use Words: _____

Combine Words: _____

Use Sentences: _____

Describe any speech/language services this child has received or presently receives: _____

_____

Date of initial session: _____ Date of final session: _____

How often? _____ Individual therapy: _____

Group therapy: _____ Where: _____

By whom: _____

Reasons for current services/current goals: _____

_____

If treatment was discontinued, please explain why: _____

_____

_____

Describe your concerns regarding this child's speech/language: _____

_____

_____

Describe your concerns regarding this child's academic performance and overall performance at present (e.g., reading level, most and least difficult subjects at school, behavior): _____

_____

_____

How much of this child's speech do you understand?
_____ less than 10% _____ 25% _____ 50% _____ 75% _____ 90% - 100%

Approximately how much of this child's speech do those less familiar with this child understand?
_____ less than 10% _____ 25% _____ 50% _____ 75% _____ 90% - 100%

Does this child become frustrated when trying to speak? If yes, please describe: _____

_____

_____

Have you talked with this child about your concerns regarding his speech/language and what was the result?

_____

_____

_____

Who has told you they are concerned with this child's speech/language and why? _____

_____

_____

CHILD'S SOCIAL HISTORY:
Does this child like school? _____

Describe how well he/she gets along with peers: _____

_____

Describe this child's favorite portion of the school day: _____

_____

Describe any support services (i.e., Chapter 1, special education, occupational therapy, etc.) this child has received or presently receives in the schools? _____

_____

_____

Please list types of books this child enjoys reading or having read to him/her: _____

_____

Please list favorite T.V. shows/videos: _____

_____

Please list favorite activities, games, toys: _____

_____

Other than academic, please list this child's

Strengths _____

_____

_____

Weaknesses _____

_____

_____

Please describe any changes you would like to see in this child's school programming within the next year:

_____

_____

_____

_____