



Pediatric Speech and Language Case History Form

Please take the time to fill out the case history form to the best of your ability. The information obtained from this form will help us with the speech and language evaluation.

Identifying and Family Information:

Child's Name: _____

Date of Birth: _____

Parent/Guardian(s) _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email address: _____

Doctor's Name: _____

Doctor's Phone: _____

Referred By: _____

Child lives with (check one):

Birth Parents Foster Parents One Parent

Adoptive Parents Parent and Step Parent Other _____

Siblings/Children in the home:

Name	Age	Sex	Speech/hearing Problems
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Child's Race/Ethnic Background:

- Caucasian, Non-Hispanic Hispanic African-American
 Native American Asian or Pacific Islander Other _____

Developmental History:

Please indicate the approximate age your child reached the following milestones:

- _____ Sat Up Alone _____ grasped/held crayon or pencil
_____ Babbled _____ Said first words
_____ Put two words together _____ Spoke in short sentences
_____ Walked independently _____ Toilet trained

Background Information of Speech and Language Problems:

Primary Language Spoken in Home: _____

Describe the speech and language problems you notice with your child: (ex: not talking, using only few words, using one word, saying words incorrectly, repeating words)

Is your child aware or frustrated by his/her speech and language difficulties? If yes, Explain Y or N

Is your child's speech and language difficulties noticed by others? If yes, please tell who. Y or N

SPEECH LANGUAGE AND BEYOND, LLC

"Taking speech and language skills over and beyond"



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Has your child received speech therapy in a school setting? Y or N

Name of School: _____

Dates of Service: _____

Results: _____

If yes, please attach a copy of Individualized Education Plan

Does your child have any problems with hearing? If yes, explain. Y or N

Does your child have any other disability? If yes, please check the appropriate box. Y or N

- | | | |
|--|---|--|
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> Intellectual Disability |
| <input type="checkbox"/> Specific Learning Disorder | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Attention Deficit Hyperactive Disorder | |
| <input type="checkbox"/> Emotional Behavior Disorder | <input type="checkbox"/> Reading Disorder | <input type="checkbox"/> Other _____ |

Current Speech and Language Function:

Receptive Language (how your child understands things said to them)

Does your child (please check what applies **only**)?

___ identify common objects (chair, table) ___ understand/follow commands (get cup, come here)

___ identify actions (run, walk, talk) ___ respond correctly to "wh" questions (who, what)

___ respond correctly to yes/no questions ___ understand basic concepts (up/down, in/out)

Expressive Language (how your child uses words to express what they understand)

___ pointing ___ babbling (ba-ba, da-da)

___ one word sentence ___ two word combinations ("want cup")

___ three or more words ___ ask questions

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___ uses position words (in/out, up/down) ___ uses descriptive words (big/little, good)

___ uses action words (walk, run, talk) ___ uses pronouns (me, mine, yours)

Articulation (how your child produces words)

___ substitute sounds (says "to" for "shoe") ___ says sounds wrong while reading

___ leaves off ending sounds ("cu" for "cup") ___ spells the way he/she speaks

___ leaves off beginning sounds ("up" for "cup")

___ says specific sounds incorrectly list sounds _____

Fluency (how smooth the flow of speech is)

___ repeats words, phrases

___ long pauses between words

___ prolongs words or sounds

___ abnormal mouth or head movements when speaking

Voice and Resonance (how voice sounds)

___ hoarse ___ strained ___ raspy

___ too low ___ to high ___ whispery

Social Skills (how your child interacts with others)

___ uses social greetings (hi, bye) ___ makes eye contact

___ plays well with others ___ shares toys/things easily

___ initiate play with others ___ takes turns



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Birth History

Was there anything unusual with the pregnancy or birth? If yes, explain. Y or N

Age of mother at birth of child: _____

Medical History

Has your child had any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> adenoidectomy | <input type="checkbox"/> encephalitis | <input type="checkbox"/> seizures |
| <input type="checkbox"/> allergies | <input type="checkbox"/> flu | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> breathing difficulties | <input type="checkbox"/> head injury | <input type="checkbox"/> sleeping difficulties |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> measles | <input type="checkbox"/> tonsillectomy |
| <input type="checkbox"/> ear infections
How often? _____ | <input type="checkbox"/> ear tubes | <input type="checkbox"/> vision problems |
| <input type="checkbox"/> high fevers | <input type="checkbox"/> thumb/finger sucking | <input type="checkbox"/> mumps |

Other serious injury/surgery: _____

Please list any allergies: _____

Please list any medications your child takes regularly:



Acknowledgement of Purpose of Case History Information

I understand that the information provided within the Pediatric Case History Form will be used to provide my child with effective evaluation and treatment. This document will be placed in my child's file and can be accessed by other third party agencies such as (primary care physician, psychologist, insurance carrier, and educational institutions) as necessary.

I also understand that if my child is currently under an Individualized Education Plan or Individualized Family Service Plan, has a psychological evaluation report, or medical report that a copy is to be provided to Speech Language and Beyond, LLC for the sole purpose of providing my child with an accurate diagnosis pertaining to communication and to provide effective and adequate treatment.

Parent/Guardian Signature: _____

Date: _____



Client Checklist:

Do I have the following or have the following already been submitted:

- Prescription or Prescription request form filled out by my child's Primary Care Physician (doctor)
- Completed Pediatric Case History Form
- Active insurance and insurance card to be photocopied and used at the time of service
- Driver's license or Personal Identification card to be photocopied and placed in my child's file
 - Any Current Individualized Education Plan or Psychological report my child is currently receiving services under.
- Private Pay Contract Signed (if this is the payment option chosen)
- Signed consent to evaluate and release information
- Copy of the Privacy Rights (which need to be printed off website and kept for your records)