Alabama A & M University
Communicative Sciences and Disorders Clinic
P.O. Box 357
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Phone: (256)372-5541 or (256)372-4044

CASE HISTORY FORM – CHILD

IDENTIFYING INFORMATION

Child's Name _____ Sex _____

Birthdate _____ Age _____ Today's Date _____

Name by which your child is called _____ Handedness Right Left **(circle)**

Address: _____ Home Phone _____

City _____ State _____ Zip _____ Cell phone _____

Parents:	Name	Age	Occupation	Education	Work #
Father	_____	____	_____	_____	_____
Mother	_____	____	_____	_____	_____

If address of either parent is different from that of child, please indicate:

Is the child adopted? _____ yes _____ no If so, at what age? _____

List children, in order of birth:

Name	Sex	Age	Grade/School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do any siblings have any speech or language difficulties? _____ yes _____ no
Specify _____

Who referred you to the AAMU Speech and Hearing Clinic? _____

Address (if professional) _____

Child's Doctor: Name _____

Address of Dr. _____
Do you want a copy of our report(s) sent to your child's doctor? _____ yes _____ no

To what other professional person(s) or agency (ies) do you want a report sent? Please include names of professionals and addresses: _____

I. STATEMENT OF THE PROBLEM

Describe in your own words what problem(s) your child is/are having with speech, language, and/or hearing.
_____

Why did you want your child evaluated by the AAMU Speech and Hearing Clinic? _____

When was the problem first noticed? _____

Who first noticed the problem? _____

What reactions does the child, parent, siblings, relatives, and/or friends have towards the problem? _____

What have you done to help your child's speech? _____
_____

If your child's speech varies, under what circumstances does it become:

Better: _____

Worse: _____

Have you sought professional advice about your child's speech, language, and/or hearing problem before?
Evaluation _____ Therapy _____ When? _____

Whom did you see?_____

Length of therapy _____

Results _____

What recommendations were made? _____

What has been done since then? _____

How does your child feel about his/her speaking ability? _____

Has your child ever been diagnosed as a "poor reader"? _____ yes _____ no
By whom was the diagnosis made? _____

Check the items that your child seems to do more than other children the same age:

_____ 1. Avoids speaking at school.
_____ 2. Avoids speaking in play situations.
_____ 3. Avoids speaking at home.
_____ 4. Avoids speaking to children (male _____, female _____).
_____ 5. Avoids speaking to adults (male _____, female _____).
_____ 6. Avoids saying certain words. (List _____)
_____ 7. Cries when unable to communicate.
_____ 8. Becomes aggressive when unable to communicate.

II. GENERAL DEVELOPMENTAL HISTORY

Was this your first pregnancy? _____ yes _____ no
If not, how many pregnancies have you had? _____ Which pregnancy was this child? _____
Any medical problems prior to this pregnancy? _____ yes _____ no
If so, please describe: _____
Did you have an illness during pregnancy? _____ yes _____ no
If so, please explain: _____
Did you have to take medication during pregnancy? _____ yes _____ no
If so, what medications? _____
Did your baby come more than two weeks early? _____ yes _____ no
Did your baby come more than two weeks late? _____ yes _____ no
Was labor longer than 24 hours? _____ yes _____ no
Was the birth by Cesarean? _____ yes _____ no
Were forceps used during the birth? _____ yes _____ no
Birth weight _____ pounds, _____ ounces
Did your baby have trouble in the hospital? _____ yes _____ no
_____ blue spell _____ yellow jaundice _____ breathing problems
_____ required oxygen _____ infection diagnosed _____ required transfusion
Other: _____
How long were mother and child in the hospital? _____
Physician's Name _____ Hospital _____

Did you bottle feed your baby? _____ yes _____ no
Did your baby cry more than average? _____ yes _____ no
Did your baby spit a lot? _____ yes _____ no
Did your baby have any feeding problems? _____ yes _____ no
Did your baby have nasal stuffiness? _____ yes _____ no
Did your baby have rattling when breathing? _____ yes _____ no
Did your have any major concerns in the first three months of your baby's life? _____ yes _____ no

Give ages at which the following first occurred:
Held head up _____ Crawled _____ Reached for objects _____
Stood _____ Walked unaided _____ Ran _____
First tooth _____ Bladder trained _____ Bowel trained _____

III. SPEECH AND LANGUAGE DEVELOPMENT

Did your child make babbling or cooing sounds during the first 6 months? _____ yes _____ no

At what age did your child say his/her first word? _____

What were the child's first words? _____

Did your child keep adding words once he/she started talking? _____ yes _____ no

At what age did your child begin using 2- and 3-word sentences? _____
Examples _____

Does your child talk frequently? _____ occasionally? _____ never? _____
Does your child prefer to talk? _____ gesture? _____ both talk and gesture? _____
Does your child most frequently use sounds? _____ single words _____ 2-word sentences _____
3-word sentences _____ more than 3-word sentences _____

Does your child make sounds incorrectly? _____ yes _____ no
If so, which ones? _____

Does your child hesitate, "get stuck", or repeat or stutter on sounds or words? _____ yes _____ no
If so, describe. _____

Describe any recent changes in your child's speech: _____

Can your child say a nursery rhyme? _____ yes _____ no
Can your child tell a simple story? _____ yes _____ no
How well can your child be understand by his/her parents? _____
Siblings? _____ Friends? _____
Relatives? _____ Strangers? _____

Does your child understand what you say to him/her? _____ yes _____ no
Can he/she follow simple commands? _____ yes _____ no
Will he/she get common objects when asked to do so? _____ yes _____ no
Does your child have trouble remembering what you have told him/her? _____ yes _____ no
If so, when does this seem to happen? _____
Does your child use any books or games? _____ yes _____ no
How often do you read to your child? _____

IV. BEHAVIORAL INFORMATION

Check these as they apply to your child:

	Yes	No	Explain: give ages, if possible
Eating problems			
Sleeping problems			
Ear infections			
Toilet training problems			
Difficulty concentrating			
Needed a lot of discipline			
Underactive			
Excitable			
Laughs easily			
Cried a lot			
Difficult to manage			
Overactive			
Sensitive			
Personality problem			
Gets along with children			
Gets along with adults			
Emotional			
Stays with an activity			
Makes friends easily			
Happy			
Irritable			
Prefers to play alone			

Describe any other type of behavior you consider to be a problem: _____
_____
_____
_____

V. EDUCATIONAL HISTORY

Does your child do average _____ below average _____ or above average _____ work in school?
What are your child's best subjects? _____
What are your child's poorest subjects? _____
Does your child receive any special assistance or help at school? _____ yes _____ no
If so, describe: _____
Has he/she repeated a grade? _____ yes _____ no
If so, which one(s)? _____
What is your impression of your child's learning abilities? _____

Describe any speech, language, hearing, psychological, and special education services that have been performed, including where this was done. Include how often your child was seen in this service. _____

VI. OTHER

What games and toys does your child prefer? _____

How many hours each day does your child watch television? _____
Which programs does he/she watch? _____

Please list what you would consider your child's favorite food(s) and snack food(s). _____

What may we use for reinforcement for your child (i.e., candy, raisins, stickers, etc.)? _____

VII. EMERGENCY CONTACT INFORMATION

Name _____ Relationship to client _____

Address _____ Home phone _____

City _____ State _____ Zip _____ Cell phone _____