



# Adults To Pediatrics Therapy, LLC

Rehabilitation Services

## SPEECH-LANGUAGE-HEARING CASE HISTORY FORM

### IDENTIFYING AND FAMILY INFORMATION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Mother's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Child lives with:

- Birth Parents                       Foster Parents                       One Parent  
 Adoptive Parents                       Parent and Step-Parent                       Other \_\_\_\_\_

### Other Children in 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? \_\_\_\_\_

**"Working together to communicate, one sound at a time."**

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**SPEECH-LANGUAGE-HEARING**

**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 your child ever had a speech evaluation/screening?**

Yes

No

If yes, where and when? \_\_\_\_\_

What were you told? \_\_\_\_\_

**Has your child 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 (e.g. physical therapy, counseling, occupational therapy, vision)?**

Yes

No

If yes, please describe: \_\_\_\_\_

**Is your child aware of, or frustrated by, any speech/language difficulties?** \_\_\_\_\_

**What do you see as your child's most difficult problem in the home?** \_\_\_\_\_

**What do you see as your child's most difficult problem in school?** \_\_\_\_\_



**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 the child stayed at the hospital, please describe why and how long he/she stayed: \_\_\_\_\_

**MEDICAL HISTORY**

**Has your child ever had any of the following?**

adenoidectomy

encephalitis

seizures

allergies

flu

sinusitis

breathing difficulties

head injury

sleeping difficulties

chicken pox

high fevers

thumb/finger sucking habit

colds

measles

tonsillectomy

ear infections

meningitis

tonsillitis

How Often? \_\_\_\_\_

mumps

vision problems

ear tubes

scarlet fever

**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:** \_\_\_\_\_

## DEVELOPMENTAL HISTORY

Please tell the approximate age your child achieved the following developmental milestones:

|       |                        |       |                          |
|-------|------------------------|-------|--------------------------|
| _____ | sat alone              | _____ | grasped crayon/pencil    |
| _____ | babbled                | _____ | said first words         |
| _____ | put two words together | _____ | spoke in short sentences |
| _____ | walked                 | _____ | toilet trained           |

Does your child:

- choke on food or liquids?
- currently put toys/objects in his/her mouth
- brush his/her teeth and/or allow brushing?

## CURRENT SPEECH-LANGUAGE-HEARING

Does your child:

- repeat sounds, words or phrases over and over?
- understand what you are saying?
- retrieve/point to common objects upon request (e.g. ball, cup, shoe)?
- follow simple directions (e.g. "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
- sounds (e.g. vowels, grunting)
- words (e.g. shoes, doggy, up)
- 2 to 4 word sentences
- sentences longer than four words
- other \_\_\_\_\_

Behavioral Characteristics:

- |  |  |
|--|--|
| <input type="checkbox"/> Cooperative                               | <input type="checkbox"/> Restless                          |
| <input type="checkbox"/> Attentive                                 | <input type="checkbox"/> Poor eye contact                  |
| <input type="checkbox"/> Willing to try new activities             | <input type="checkbox"/> Easily distracted/short attention |
| <input type="checkbox"/> Plays alone for reasonable length of time | <input type="checkbox"/> Destructive/aggressive            |
| <input type="checkbox"/> Separation difficulties                   | <input type="checkbox"/> Withdrawn                         |
| <input type="checkbox"/> Easily frustrated/impulsive               | <input type="checkbox"/> Inappropriate behavior            |
| <input type="checkbox"/> Stubborn                                  | <input type="checkbox"/> Self –abusive behavior            |

