Speech-Language Pathology Services
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Client Personal Information/Case History

(This information will be kept confidential)

Name:	Date of Birth:
Parents/Guardians:	Age:
Address and Postal Code:	Phone number:
Email Address:	School and Grade:

The evaluation of your child's speech and language requires information about his/her hearing, speech, language, developmental, and medical history. Please fill out this form as completely as possible and return it to the above address, or bring it with you at the time of your appointment.

Today's date: ____

Person completing this form: ________________________________

Relationship to child: _____________________________________

Referred by: ____

Name of Child's Doctor: ___________________________________

HEARING/SPEECH/LANGUAGE HISTORY

1. Please describe your child's communication difficulties.

____

____

2. When was the problem first noticed?

____

3. Who first noticed the problem?

____

4. What do you think caused the problem?

____

____

5. What changes in your child's language, speech, or hearing have you noticed since that time?

____

____

____

6. Have you consulted other persons about the problem? (Circle one) Yes No

____

____

7. Has your child had any prior speech-language or hearing evaluations/assessment?

Circle one: Yes No

If yes,

a. When? ____

b. Who/Where? ____

c. What were the results? ____

____

8. Has the child been seen for any prior speech-language or hearing therapy?

Circle one: Yes No

If yes,

a. When? ____

b. Who/Where? ____

c. What were the results? ____

9. What language(s) is/are spoken at home? ________________________________

10. At what age did this child:
   a. Babble and coo? ________________________________
   b. Say his/her first word? ________________________________
   c. Begin to use two-word phrases? ________________________________
   d. Begin to use sentences? ________________________________

11. How well can he/she be understood by:
   a. Parents? ________________________________
   b. Sisters and/or brothers? ________________________________
   c. Strangers? ________________________________
   d. Relatives and/or friends?________________________________

12. Approximately how many words are in your child's vocabulary?

____

13. Which does this child prefer to use? Circle those that apply:

Gestures
Sounds
Single words
Two-word phrases
Sentences

14. Are you concerned about your child's ability to understand directions and conversation? Yes No
If yes, please explain why:

____

____

____

15. Are you concerned about your child's ability to express himself/herself? Yes No
If yes, please explain why:

____
____
____

DEVELOPMENTAL/MEDICAL HISTORY

1. Were there any concerns/complications during pregnancy? Yes No
   If so, which month of gestation? ____________
   Was hospitalization necessary? Yes No
   If yes, please explain why: ____
   ____

2. What was the length of this pregnancy? __________________________________

3. Were there any difficulties at birth? Yes No
   If yes, please describe:
   ____
   ____
   ____

4. As a baby, did your child breastfeed or bottle-feed? Were there any difficulties with feeding then?
   ____
   ____

5. Has your child had any surgeries or serious medical conditions since birth (e.g., whooping cough, mumps, chicken pox, allergies, ear infections, tonsillectomy, epilepsy, chronic colds, pneumonia, head injury…): Yes No
   If yes, please describe: ____
   ____

5. Is your child taking any medications? Yes No
   If yes, please describe: ____

6. Does your child demonstrate any sensory preferences/dislikes (e.g. avoid loud noises or certain food textures or seek deep pressure/tight hugs)?
   ____
   ____

FAMILY HISTORY

1. Does your child have siblings? Circle: Yes No
Name(s) & Age(s): ____
Gender(s): ____

2. Has anyone in your family had any speech-language difficulties (child's mother, father, siblings, etc.)? Circle: Yes No
If yes, please describe: ____
____

3. Who are your child's primary caregivers (i.e., people living in the home, daytime caregivers, etc.)?
____
____

SOCIAL/BEHAVIORAL/EDUCATIONAL HISTORY

1. Does your child play alone or with other children? How does he play with them?
____
____
____
____

2. Does your child attend preschool/school? If so, what days/times?
____
____
____

3. Please describe your child's temperament:
____
____
____

ASSOCIATED SERVICES

Has your child seen an Occupational Therapist, Physiotherapist, Psychologist, Behavioral Consultant or other relevant professional? Circle: Yes No
If yes, please explain.

Did your child receive a diagnosis? (example: Autism Spectrum Disorder)
Circle: Yes No
If yes, please state.

Thank you for completing this form.