



SPEECH-LANGUAGE THERAPY CASE HISTORY

Please complete this form before your child's Speech-Language Therapy Evaluation. If there are questions you do not wish to complete, please leave them blank.

At what age did your child do the following?

Begin to babble? _____

First say meaningful words? _____

Name most people and objects? _____

Combine words into 2 word phrases (e.g. "want drink")? _____

Use more complete sentences (e.g. "I want to play ball")? _____

Does your child seem to understand what is said to him/her? Yes No

Does your child have difficulty following directions? Yes No

Does your child have difficulty with feeding or swallowing (e.g. coughing, choking, or gagging) at this time? Yes No

If yes, please explain: _____

How much of your child's speech do you understand?

Less than 50%

50 to 75%

75% to 90%

Greater than 90%

Other: _____

How does your child currently communicate wants and needs (e.g. pointing, speech, sign language, etc.)? _____

Who first noted concern with your child's speech, language, hearing or swallowing skills? When? _____

Does your child appear frustrated with communication? Yes No

Is your child aware of his/her difficulties, and if so, what is his/her reaction to the problem? _____

How have you attempted to help your child with his/her difficulties? _____

Patient Label

How much screen time (computer, tablet, phone, video games, TV, etc.) does your child engage in each day? _____
_____ (estimate of time)

What language/s are spoken in the home? _____

Does your child use a pacifier? Yes No

Does your child suck his/her thumb and/or fingers? Yes No

Mother's highest level of education completed:

Grade in School 8 or less 9 10 11 12 or GED

Years of College 1 2 3 4

Graduate School Yes No

Father's highest level of education completed:

Grade in School 8 or less 9 10 11 12 or GED

Years of College 1 2 3 4

Graduate School Yes No

Patient Label
