Mary Barry and Associates, LLC
Speech and Language Pathologists
Phone: (630) 654-8888

FOR OFFICE USE ONLY
Date of Eval:_____
Time of Eval:_____
C.A.:_____

Case History Questionnaire

Child

THIS FORM MUST BE COMPLETED AND RETURNED AT THE TIME OF YOUR APPOINTMENT. THANK YOU FOR YOUR COOPERATION.

In your own words, describe your child's communication problem. Please indicate when you first noticed the problem and if there have been any recent changes.

GENERAL INFORMATION

Child's Name: _____Date of Birth: _____

Address: _____

Home Phone: _____Business Phone: _____

Cell Phone: _____E-Mail Address: _____

Name of Person Filling Out the Questionnaire: _____

Relationship to Child: _____

Mother's Name: _____

Mother's Occupation: _____

Father's Name: _____

Father's Occupation: _____

Referral Source (e.g., teacher, doctor, etc.): _____

Referral's Name: _____

Address: _____

Contact Phone Number: _____

Permission to contact referral source? Yes ___No___

FAMILY HISTORY

Sibling(s) Name(s): _____ Date of Birth: _____

_____ _____

_____ _____

_____ _____

Other people living in the home: Relationship to the child:

_____

_____

What is the child's primary language? _____

Are any other languages spoken in the home? _____

Are there any other family members who have received speech/language therapy services? If yes, please explain.

PRE-NATAL AND BIRTH HISTORY

During this pregnancy or delivery, did mother experience any unusual illness, condition, or accident such as German measles, Rh incompatibility, special medical care, false labor, etc.? _____
If yes, please describe:

_____

_____

_____

Substances used during pregnancy: Cigarettes___ Alcohol___ Drugs___ None____

Length of Pregnancy: _____ Birth Weight: _____

APGAR scores (if known): _____

Birth was: Normal_____ Caesarean_____ Breech_____ Multiple Birth_____

If a C-section was done, please explain why._____

Was your child in the Neonatal Intensive Care Unit (NICU)? _____

If so, how long? _____

Please check those conditions that applied to your child immediately following birth:
_____difficulty breathing _____sucking problems _____seizures _____blue skin
_____swallowing difficulties _____scars and bruises _____jaundice
_____feeding problems _____cord wrapped around neck _____genetic disorder
_____meningitis _____AIDS (HIV)

Were there any complications during or immediately following delivery? If yes, please explain.
Please describe any unusual events or problems during the first year. _____
_____
_____

HEALTH HISTORY

Describe your child's current health status.

Present weight_____ Present height_____

Has your child suffered any of the following illnesses or conditions? If so, please provide age of occurrence. Please add any others not listed.
____Measles ____Scarlet Fever ____Brochitis ____Chicken Pox ____Croup
____High Fevers ____Mumps ____Tonsillitis ____Laryngitis ____Convulsions
____seizures ____Asthma ____Frequent cases of flu
____Ear Infection(s) Were tubes inserted?_____ If so, when? _____
____Allergies (hay fever, food, medications): Please list:_____
Other_____

Describe any accidents, head trauma, surgeries or hospitalizations that your child has had.

Is your child under a doctor's care? If so, for what condition? What medications, if any, is your child currently taking?

DEVELOPMENTAL HISTORY

Provide the approximate age at which your child did the following:

Sit up _____ Crawl_____ Stand_____
Walk_____ Become toilet-trained_____

Do you have any concerns about your child's development in any of the following areas?

Gross Motor (walking, running, physical activities) Yes_____ No_____
Fine Motor (use of pencil, manipulation of objects) Yes_____ No_____
Independent Functioning (eating, dressing self) Yes_____ No_____

If you checked "yes" to any of the above areas, please describe your concerns.

Briefly describe any other concerns you have regarding your child's development.

Has your child ever experienced feeding difficulties (e.g., reflux, sucking, swallowing, drooling, etc.)?
Yes_____ No_____
If yes, please describe.

SPEECH/LANGUAGE/HEARING HISTORY

Provide the approximate age at which your child did the following:

Babbled & vocalized (e.g., ooo-bababa)? _____
Said first word?_____What was your child's first word? _____
How does your child currently communicate (e.g., gestures, verbally, etc.)?

Did your child ever start talking, then stop?_____If so, please describe:_____
_____

Which does your child prefer to use? Sounds____ One or two words_____ Phrases_____
Complete sentences_____ Gestures____ Please give examples: _____
_____
At what age did your child use word combinations like "Want cookie" or "Me out?"_____
_____
At what age did your child use more complete sentences like "Mommy go shopping" or "I fall down"?
_____
How does your child's voice sound?
Normal_____ Too high pitched _____ Too low pitched_____ Hoarse_____ Nasal_____
Does your child hesitate, "get stuck," repeat, or stutter on sounds or words?_____
_____
Approximately what percentage of the time can your child be understood?
By parents_____ By siblings_____
By playmates_____ By strangers_____
Does your child seem to be aware of speaking differently from others? If so, describe:
_____
_____
Does your child seem to have any difficulty hearing?_____
Does his/her hearing appear to vary or is it constant?_____
Does he/she hear less when he/she has a cold?_____
Has your child ever worn a hearing aid?_____ Which ear?_____ How long?_____
Does your child seem to have any difficulty understanding speech or directions?
Please describe:_____
_____
Does your child follow simple commands? Yes_____No_____
Does your child seem to understand two and three-step directions? Yes_____No_____
Does your child seem to understand what is being said to him/her? Yes_____No_____
Have your child's speech and language skills been tested in the past? Yes_____No_____
If so, when and where were they tested and what were the results?

Date of last hearing test? _____ Location of test? _____
Were the results normal? Yes_____No_____ If no, please explain.

Date of last vision test?_____Were the results normal? Yes_____No_____
If no, please explain.

Check any of the following diagnoses that apply to your child:

____Cleft Lip and/or Palate ____Attention Deficit Disorder ____Central Auditory
____Pierre Robin Sequence ____Attention Deficit Processing Disorder
____Tourette's Syndrome Hyperactivity Disorder ____Seizure Disorder____Down Syndrome
____Language Learning Disability ____Hearing Loss ____Developmental Delays
____Pervasive Developmental ____Autism Disorder
____Other:_____

SOCIAL HISTORY

Describe your child's personality. Would you describe your child as quiet/shy or talkative/friendly?

Describe how your child interacts with peers.

Describe how your child interacts with adults.

What are your child's favorite activities/hobbies?

EDUCATIONAL HISTORY

School_____
Current Grade_____
Teacher's Name_____
Contact Phone Number_____
Does your child have an IEP (Individualized Education Plan)? Yes_____No_____
If yes, what is the designated disability classification? _____
Is your child receiving any special services in school? Yes _____ No_____ If yes, please list the services.

List any support services/modifications provided in school.

Check any of the following conditions that are of concern to you about your child:

General intellectual level _____ Difficulty with planning and organization_____
Difficulty completing an activity _____ Difficulty adapting to change_____
Easily distracted_____ Difficulty expressing self_____ Inability to concentrate_____
Difficulty with written expression_____ Difficulty reading_____
Difficulty learning/remembering new information_____
Please include any additional information related to the above-noted conditions.

OTHER EVALUATIONS

Has your child had a speech-language evaluation prior to this time?_____
When, where, and with whom?_____
What were the results?_____
_____
Does your child receive speech-language therapy now or has he/she ever received it?
_____
What is or was the nature of the therapy?_____
_____
Has your child had a hearing test or central auditory processing evaluation prior to this time?
_____
When and where?_____
What were the results?_____
Has your child had a neurological evaluation prior to this time?_____
When and where?_____
What were the results?_____
Has your child had a recent medical examination?_____
When and where?_____
What were the results?_____

ADDITIONAL INFORMATION

Are you concerned about any behavioral problems?_____
If so, describe:_____
_____
_____
In your own words, describe your child's personality:_____
_____
_____
_____
_____
If there is additional information that might help us to understand your child and his/her communication better, please describe:_____
_____