CLEVELAND STATE UNIVERSITY ~ SPEECH & HEARING CLINIC

Speech/Language: Preschool Case History

Background Information

Name: _____ DOB: _____ Age: _____

Address: _____

Circle Preferred Contact: [H] _____ [W] _____

[Cell]_____ [Pager] _____

Mother's name: _____ Occupation: _____

Father's name: _____ Occupation: _____

Pediatrician: _____ Phone: _____

Person completing this form: _____ Referred by:_____

Statement of the Problem

Describe your concerns with your child's speech or language problems. _____

_____

When was the problem first noticed?_____

_____

Has the problem changed since you first noticed it?_____

_____

Are you also concerned about your child's hearing? _____ If yes, explain: _____

_____

Social and Environmental Factors

Is there a family history of a speech, language, hearing or learning disorder? _____ If yes, explain:

_____

With whom does your child live?_____

Indicate siblings or any other individuals living with your child:

Names	Ages	Relationship

Who does your child stay with during the day?_____

Who is the caretaker when the parent is not available? _____

Describe any unique family circumstances that have a significant impact on this child's development:

_____

Pregnancy and Birth History

Length of pregnancy_____ Birthweight_____

Describe complications, illnesses or accidents during pregnancy or delivery (cesarean / breech birth, etc.):

_____

Did your child come home from the hospital with you?_____ If not, please explain:_____

_____

Did your child have feeding problems or colic? _____ If so, describe:_____

_____

Was this child adopted? _____ Is the child in foster care?_____

Medical History

Was your child ever hospitalized? _____ If so, describe_____

Check ☑ if your child has ever had the following and if so, describe.

- ☐ Seizures – describe_____
- ☐ High fevers – describe_____
- ☐ Allergies (food or environmental) – describe_____
- ☐ Middle ear infections – How many?_____ Last ear infection_____

  Method of treatment_____
- ☐ Major injury – describe_____
- ☐ Acid Reflux – describe_____

List present medications and reason for the medication:_____

_____

_____

What other medical professionals has your child seen and for what reason? _____

_____

_____

Developmental History

Check ☑ how your child typically communicates:

☐ Sounds/noises ☐ 1 or 2 word phrases ☐ complete sentences

☐ Gestures ☐ phrases ☐ does not communicate

Did your child coo and babble during the first six months? _____

At what age did your child speak his/her first words? _____

When did your child begin to use two-word phrases? _____

Does your child produce sounds correctly? _____ If no, explain: _____

_____

Did your child every acquire speech and then slow down or stop talking? _____ If yes, describe:

_____

At what age did your child:

Sit unsupported_____ Toilet trained/day_____

Crawl_____ Toilet trained/night_____

Walk unaided_____ Sleep through the night_____

Dress self_____ Feed self_____

Does your child use a pacifier? _____ If yes, under what circumstances: _____

_____

Play and Behavior

Check ☑ which of these traits are characteristic:

☐ well-behaved ☐ irritable ☐ easy to manage

☐ overactive ☐ happy ☐ impulsive

☐ cries/whines often ☐ distractible ☐ destructive

☐ under-active ☐ slow to respond ☐ sucks thumb

☐ difficult to manage ☐ easily excitable ☐ good eater

☐ shy ☐ stubborn ☐ drools

☐ sensitive ☐ has a poor memory ☐ fights with others

☐ runs away when called ☐ good problem-solver ☐ talkative

☐ attentive ☐ bangs head ☐ repeats an activity over & over

☐ poor eater ☐ has temper tantrums ☐ has difficulty concentrating

☐ gets along with other children ☐ wets bed (except TV)

☐ easily discouraged ☐ gets along with adults ☐ prefers to play alone

How do you discipline your child?_____

_____

Education and Intervention History

Check ☑ if your child has ever participated in the following activities. If yes, please list the dates of therapy, contact person, address and phone number below.

☐ Speech therapy ☐ Physical therapy ☐ Early Intervention Services

☐ Occupational therapy ☐ Social Services ☐ Child care, preschool or Head Start

_____

_____

_____

_____

Additional Information

If there is any additional information you would like to provide concerning your child, please explain below: _____

_____

_____

_____

SAN/DL: 7/02

B. What is the child currently doing?

Please check **ONE** box in each section that most closely describes what the child is doing now.

Method Used: (✔) Check ☐ Observation ☐ Structured Interview

Name and Title of Person Completing Form:_____

Eating
- ☐ Needs to be fed
- ☐ Picks up food and eats with fingers
- ☐ Feeds self with spoon
- ☐ Eats and drinks independently

Dressing
- ☐ Needs to be dressed
- ☐ Removes small articles of clothing
- ☐ Puts on some clothes such as socks, shirt, and/or pants
- ☐ Dresses self except shoes

Toileting
- ☐ Wears diapers
- ☐ Uses potty with help or with reminders
- ☐ Independent

Attention
- ☐ Needs constant attention/supervision
- ☐ Occupies self with toys for 10 or more minutes
- ☐ Attends to small-group activity for 10 or more minutes

Receptive Communication
- ☐ Does not appear to understand words
- ☐ Shows understanding of several words (e.g., "mommy" or "pop")
- ☐ Can follow simple directions such as "Give Daddy the ball"

Expressive Communication
- ☐ Uses gestures and/or sounds
- ☐ Says at least 10 words you can understand
- ☐ Says two or three words together
- ☐ Can carry on a simple conversation
- ☐ Repeats easy rhymes/jingles
- ☐ Can be understood by people not familiar with his/her speech

Hearing
- ☐ Does not respond regularly to sounds
- ☐ Looks at or reacts correctly to sources of sounds (looks at phone when it rings, looks out the window when a truck passes, turns when name is called)
- ☐ Responds to simple directions given when back is turned

Cognitive
- ☐ Looks for toy or person who is out of sight
- ☐ Shows understanding of how things work by turning things on/off, activating a variety of toys or directing adults to do so
- ☐ Sorts toys or objects by at least one feature (e.g., color, size, shape)
- ☐ Counts to four and names two or three colors

Fine Motor
- ☐ Needs help to pick up small pieces of food or small toys
- ☐ Independently picks up small toys and transfers from hand to hand
- ☐ Scribbles on paper
- ☐ Draws some recognizable shapes/pictures

Play
- ☐ Needs stimulation to be provided by another person
- ☐ Holds and manipulates toys (e.g., shakes, chews, bangs)
- ☐ Uses some toys and objects appropriately (e.g., pushes truck, rocks baby, uses brush to brush hair)
- ☐ Uses imagination to play (e.g., pretends to cook dinner, pretends to be Mommy going to work, dresses like Daddy)

Gross Motor
- ☐ Needs to be carried or moved by another person
- ☐ Crawls
- ☐ Walks holding onto furniture
- ☐ Walks independently
- ☐ Demonstrates balance and coordination (e.g., jump/hop)

Vision
- ☐ Does not show recognition of people or objects by sight
- ☐ Recognizes familiar people and toys, locates familiar objects in the house (e.g., shoes, tooth brush, TV)
- ☐ Points to and names things and people in pictures

Social
- ☐ Shows little response to other people
- ☐ Enjoys frolic play, peek-a-boo, pat-a-cake
- ☐ Plays along side other children (parallel play)
- ☐ Sometimes shares toys and cooperates in play
- ☐ Takes turns in simple games (e.g., Duck, Duck Goose, The Farmer in the Dell)