

CLEVELAND STATE UNIVERSITY ~ SPEECH & HEARING CLINIC  
**Speech/Language: School Age 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. \_\_\_\_\_

When was the problem first noticed? \_\_\_\_\_

Has the problem changed since you first noticed it? \_\_\_\_\_

How does the communication problem interfere with your child's typical daily routines? \_\_\_\_\_

**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? \_\_\_\_\_

Was this child adopted? \_\_\_\_\_ Is the child in foster care? \_\_\_\_\_

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:

Indicate siblings or any other individuals living with your child:

Names	Ages	Relationship

**Medical History**

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 \_\_\_\_\_

Was your child ever hospitalized? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

List present medications and reason for the medication: \_\_\_\_\_

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

**Developmental and Communication History**

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 ever acquire speech and then slow down or stop talking? \_\_\_\_\_ If yes, describe:

Does your child have difficulty walking, running or participating in gym activities? \_\_\_\_\_ If yes explain:

Does your child hesitate, "get stuck" on words, hold his/her breath, repeat or stutter on sounds or words?

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

Check  if any of the following describes your child's voice quality:

- normal     nasal     high pitch     monotone     hoarse     low pitch

Do you consider your child to understand directions and situations as well as other children the same age?

\_\_\_\_\_ If not, describe: \_\_\_\_\_

Does your child hear adequately? \_\_\_\_\_ Does his/her hearing appear to fluctuate? \_\_\_\_\_

Has your child's hearing ever been tested? \_\_\_\_\_ If yes, explain when, by whom and the results:

Are there other languages spoken in the home? \_\_\_\_\_

### **Behavior History**

Check  which of these traits are characteristic:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> well-behaved                   | <input type="checkbox"/> easily discouraged     | <input type="checkbox"/> easy to manage                  |
| <input type="checkbox"/> overactive                     | <input type="checkbox"/> happy                  | <input type="checkbox"/> impulsive                       |
| <input type="checkbox"/> cries/whines often             | <input type="checkbox"/> distractible           | <input type="checkbox"/> destructive/aggressive          |
| <input type="checkbox"/> under-active                   | <input type="checkbox"/> slow to respond        | <input type="checkbox"/> sucks thumb                     |
| <input type="checkbox"/> difficult to manage            | <input type="checkbox"/> easily excitable       | <input type="checkbox"/> fights with others              |
| <input type="checkbox"/> shy                            | <input type="checkbox"/> stubborn               | <input type="checkbox"/> talkative                       |
| <input type="checkbox"/> sensitive                      | <input type="checkbox"/> has a poor memory      | <input type="checkbox"/> good problem-solver             |
| <input type="checkbox"/> runs away when called          | <input type="checkbox"/> gets along with adults | <input type="checkbox"/> attentive                       |
| <input type="checkbox"/> prefers to play alone          | <input type="checkbox"/> bangs head             | <input type="checkbox"/> repeats an activity over & over |
| <input type="checkbox"/> picky eater                    | <input type="checkbox"/> has temper tantrums    | <input type="checkbox"/> has difficulty completing       |
| <input type="checkbox"/> gets along with other children | <input type="checkbox"/> wets bed               | homework   |
| <input type="checkbox"/> has many friends               | <input type="checkbox"/> has few friends        |  |

How do you discipline your child? \_\_\_\_\_

How many hours of TV does your child watch daily? \_\_\_\_\_ What are his/her favorite shows?

Does your child have emotional, adjustment or behavior problems? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

**Education and Intervention History**

Check  if your child has ever participated in the following activities. If yes, please list the dates of service/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
- An MFE (Multi-Factored Evaluation) at school

Does your child have a current IEP (Individualized Education Program)? \_\_\_\_\_

What school does your child attend? \_\_\_\_\_

How does your child feel about school and his/her teachers? \_\_\_\_\_

Check  if your child has problems with any of the following at school.

- listening
- reading
- behavior
- attending to an activity
- playing
- spelling
- making friends
- writing
- math
- expressive language

**Additional Information**

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