

**Brigham Young University**  
Speech-Language Pathology Clinic

**CASE HISTORY FORM-Child**

*Please fill out this form as completely as possible, especially the questions marked with an asterisk\* If you need more space, write on the last page, or add a sheet. Please call 422-2870 if you have additional questions regarding these forms.*

Date: \_\_\_\_\_

Person filling out this form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**Identifying Information**

\*Child's name: \_\_\_\_\_ \*Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: F M

\*Parents or Guardians: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Best time to call: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

\*Reason for referral: \_\_\_\_\_ Referring person: \_\_\_\_\_

**History of Problem**

\*Describe present problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Who noted present problem? \_\_\_\_\_ When? \_\_\_\_\_

\*What is your child's reaction to the problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*How does the family react to the problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has there been any significant change in last six months? \_\_\_\_\_ If so, what? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*How well is your child understood by: (i.e., what percentage of the time)

Mom: \_\_\_\_\_ Dad: \_\_\_\_\_ Younger siblings: \_\_\_\_\_ Older siblings: \_\_\_\_\_

Other children: \_\_\_\_\_ Extended family: \_\_\_\_\_ Unfamiliar adults: \_\_\_\_\_

\*Describe what it is like to have a conversation with your child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*Any previous assessments? Y N Where? \_\_\_\_\_ By whom? \_\_\_\_\_

\*What kind? \_\_\_\_\_

\*What were the results? \_\_\_\_\_

\*Which tests were given? \_\_\_\_\_

\*Any previous therapy? Y N Where? \_\_\_\_\_ With whom? \_\_\_\_\_

## Health History

### Birth History

What was the length of the pregnancy? \_\_\_\_\_

\*Were there any illness or accidents during pregnancy? (explain) \_\_\_\_\_

\*Were drugs or alcohol used during pregnancy? (aspirin and/or other medication) Y N If so, what? \_\_\_\_\_

What was the length of labor? \_\_\_\_\_ \*Any difficulties at birth, including Caesarian?(describe): \_\_\_\_\_

Were drugs used? \_\_\_\_\_ Instruments? \_\_\_\_\_ Bruises to head? \_\_\_\_\_

What was the mother's age: \_\_\_\_\_ Mother's health at time of pregnancy and birth was: \_\_\_\_\_

What was the final Apgar score? \_\_\_\_\_ Any jaundice? Y N cyanosis? Y N Rh incompatibility factors? Y N

### Medical History

\*Please check if your child has had any of the following (and if so, at what age):

_____ Seizures	_____ High fevers	_____ Measles	_____ Mumps
_____ Chicken pox	_____ Whooping cough	_____ Diphtheria	_____ Croup
_____ Pneumonia	_____ Tonsillitis	_____ Meningitis	_____ Encephalitis
_____ Rheumatic fever	_____ Tuberculosis	_____ Sinusitis	_____ Chronic colds
_____ Enlarged glands	_____ Thyroid	_____ Asthma	_____ Heart trouble

Please explain any checked items here: \_\_\_\_\_

Are immunizations current? \_\_\_\_\_ Current general health: \_\_\_\_\_

\*\*Has your child had any earaches/ear infections? Y N Please explain here: \_\_\_\_\_

Allergies? (Describe) \_\_\_\_\_

Any other serious or recurrent illnesses? \_\_\_\_\_

Any operations? \_\_\_\_\_

Any accidents? \_\_\_\_\_

Any medications? (Past) \_\_\_\_\_ (Current) \_\_\_\_\_

Vision problems? \_\_\_\_\_ Treatment: \_\_\_\_\_

\*Hearing difficulties: \_\_\_\_\_ Treatment: \_\_\_\_\_

Dental problems? \_\_\_\_\_ Treatment: \_\_\_\_\_

Other Medical History: \_\_\_\_\_

**\*\*If your child has had chronic ear infections and/or had tubes placed in his or her ears, please attach or have a statement sent from your doctor regarding dates and results of treatment.**

Personal Medical Information

Personal Primary Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Address or Location: \_\_\_\_\_

Ongoing Medical Care (Describe): \_\_\_\_\_

Physician's Name: \_\_\_\_\_ City: \_\_\_\_\_

<u>Current Medications:</u>	<u>Dosage:</u>	<u>Physician:</u>	<u>Location:</u>
_____	_____	_____	_____
_____	_____	_____	_____

Chronic Health Problems (Asthma, Congenital Defects, etc.): \_\_\_\_\_

Handicaps (Describe, if any): \_\_\_\_\_

**Developmental History**

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed)

sat up alone \_\_\_\_\_ crawled \_\_\_\_\_ walked \_\_\_\_\_ toilet trained \_\_\_\_\_ dressed self \_\_\_\_\_

tied shoes \_\_\_\_\_ fed self independently \_\_\_\_\_ Is the child left or right handed? \_\_\_\_\_

Attention span-for self-directed activities: \_\_\_\_\_

\*Attention span for adult-directed activities: \_\_\_\_\_

Eating and sleeping patterns: \_\_\_\_\_

Does your child respond to: Light? \_\_\_\_\_ Sound? \_\_\_\_\_ People? \_\_\_\_\_

Does your child: Play with others? \_\_\_\_\_ Who? \_\_\_\_\_

Eat and sleep well? \_\_\_\_\_ Cry appropriately? \_\_\_\_\_ Laugh? \_\_\_\_\_ Smile? \_\_\_\_\_

Make wants known? \_\_\_\_\_ How? \_\_\_\_\_

Does your child show unusual behavior (explain)? \_\_\_\_\_

**Language Development**

Language(s) spoken in home: \_\_\_\_\_

\*Age when your child spoke first word: \_\_\_\_\_ \*combined words: \_\_\_\_\_ \*spoke in sentences: \_\_\_\_\_

\*What was your child's first word(s)? \_\_\_\_\_ \*first sentence? \_\_\_\_\_

\*Which sounds (if any) are incorrect? \_\_\_\_\_

\*How many words can your child say? (list if fewer than fifteen) \_\_\_\_\_

\*How long are your child's sentences? \_\_\_\_\_

\*Does your child have any difficulty understanding you? (describe) \_\_\_\_\_

\*Does your child have difficulty following directions? (describe) \_\_\_\_\_

\*Any speech or hearing problems in the immediate or extended family (explain)? \_\_\_\_\_

**Social Development**

Names and ages of siblings: \_\_\_\_\_

Other adults living in the home: \_\_\_\_\_

Moves prior to age 10: \_\_\_\_\_

Has your child attended day care? \_\_\_\_\_ Nursery School? \_\_\_\_\_

Number of regular playmates: \_\_\_\_\_ Ages: \_\_\_\_\_ Genders: \_\_\_\_\_

Activities shared with parents and siblings: \_\_\_\_\_

\*How does your child handle frustration: \_\_\_\_\_

conflict: \_\_\_\_\_ separation: \_\_\_\_\_

Regular responsibilities: \_\_\_\_\_

Favorite places: \_\_\_\_\_ people: \_\_\_\_\_ toys: \_\_\_\_\_

snacks: \_\_\_\_\_ activities: \_\_\_\_\_ TV programs: \_\_\_\_\_

What motivates your child most? \_\_\_\_\_

What discipline methods work best? \_\_\_\_\_

**School History**

School experience: \_\_\_\_\_

How does your child's teacher describe his/her performance? \_\_\_\_\_

\_\_\_\_\_

Has the teacher expressed any concern? If so, what? \_\_\_\_\_

**Other**

\*What do you hope to have happen as a result of this evaluation? \_\_\_\_\_

\*Does the report need to be sent to specific agencies? \_\_\_\_\_ Where? \_\_\_\_\_

\_\_\_\_\_

\*Anything else you would like us to know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\* PLEASE MAIL THESE COMPLETED FORMS, ALONG WITH ANY OTHER APPLICABLE CASE HISTORY FORMS (EX. VOICE, FLUENCY, ACCENT REDUCTION) TO:**

**BRIGHAM YOUNG UNIVERSITY  
ATTN: SPEECH-LANGUAGE CLINIC  
136 TLRB  
PROVO, UT 84602**

**PLEASE SEND RELEVANT REPORTS AND INFORMATION FROM OTHER AGENCIES IN A SEPARATE ENVELOPE.**