



Child Case History

General Information

Today's Date: _____
Child's Name: _____ Date of Birth: _____ Gender: _____
Address: _____ Age: _____
City: _____ State: _____ Zip: _____
Home Phone: _____

Does the child live with both parents? Both Parents: ___ Mother: ___ Father ___ Guardian: ___

If divorced, who has custody? Joint: ___ Mother: ___ Father: ___ Other: ___

Who does child spend most of his/her time with? _____

Mother's Name: _____ Father's Name: _____

Occupation: _____ Occupation: _____

Home: _____ Home: _____

Cell: _____ Cell: _____

E-mail: _____ E-mail: _____

Siblings:	Age:	Other People in the home:	Relation:
_____	_____	_____	_____

_____	_____	_____	Relation: _____
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_____	_____	_____	Relation: _____
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Child's Physician: _____ Phone number: _____

Address: _____ City: _____

What language (s) does the child speak? _____

How does the child usually communicate?

Gestures Sign Language Single Words Short Phrases Sentences

How does your child tell what he/she wants? _____

Does he/she follow directions?

Do you feel like he/she understands most of what you say? _____

When did you first become concerned? _____

Since you first became concerned, what changes have you observed in your child's speech, language, or hearing? _____

Describe other speech, language, or hearing problems in the family. _____

Please check appropriate box:	Yes	No	Unknown	Comments
Is the child adopted?				If yes, at what age did the child join the family?
Normal pregnancy and delivery?				
Weight at birth?				
Vaginal delivery?				
Cesarean delivery?				
Full-term pregnancy?				

Alcohol, drugs, smoking, or any medications during this pregnancy? If so, please list.				
Did your child have jaundice?				
Was oxygen or respiratory assistance required after birth?				
Was your child breast fed?				
Any difficulties with feeding?				
Did your child have normal feeding, weight gain, sleeping cycles, and temperament?				

Prenatal and Birth History

Describe mother's general health during pregnancy (illness, accidents, prescription and non-prescription medications, etc.).

Length of pregnancy: _____

Medical History:

Child's general health is: Good Fair Poor

Is your child on any medications? _____

Describe any major illnesses, accidents, surgeries, or hospitalizations the child has had.

Has your child had ear infections? _____ How many? _____

Does your child have tubes? _____

Developmental History

Please complete this section to the best of your ability.

Write the approximate age when the child began to do the following.

Crawl _____ Sit _____ Stand _____ Walk _____ Feed Self _____

Dress self _____ Use toilet _____ Use single words _____ Combine words _____

Name simple objects _____ Use simple questions _____

Engage in a conversation _____

Does your child have any motor difficulty, such as walking or running? _____

Describe any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.) your child has had. _____

Does your child:

Respond to sounds? _____ Respond to sounds inconsistently? _____

Do you suspect any problems with hearing? _____

General Behavior

Do you have any concerns with eating or sleeping? _____

How does the child interact with other family members? _____

How does the child interact with other children? _____

Do you have any other relevant concerns? _____

Educational History:

School or Preschool: _____ Grade: _____

Teacher (s): _____

Describe any special services your child receives. _____

If enrolled for special education services, list main goals of the Individualized Educational Plan (IEP) or Individual Family Service Plan (IFSP). _____

How did you hear about The TALK Team?

Family Member: _____

Internet: _____

Friend: _____

Phone book: _____

Teacher: _____

Workshop: _____

Doctor: _____

Insurance network: _____

The information provided in this document regarding my child is accurate and consistent to the best of my knowledge.

Signature: _____ Date: _____

Relationship to the patient: _____

