Center for Speech and Language Disorders

Therapy that makes a difference

Main Office: 310-D S. Main St. • Lombard, IL 60148
Phone: 630-652-0200 ** Fax: 630-652-0300
info@csld.org • www.csld.org
Chicago site: 820 N. Orleans St., Ste 217
Phone: 630-652-0200 ext 201

Case History / Medical History

Client Information

Date_______________________

Name: ____ Male / Female

Address:______________________________ City:___________________________ ST:____ ZIP:_____________

DOB: __________________ Age: _____ Ph : ____

Child's Physician:____

Address:_______________________________City: _________________________ ST:____ ZIP: _____________

Phone: ______________________________ Medical Insurance:____

Id #___________________ Group Number: _______________ Primary policy holder:_______________________

What language(s) are spoken in the home? ____

Please describe your concerns regarding your child's speech, language, and/or literacy development:

____

____

Do you have any concerns regarding your child's hearing ☐ No ☐ Yes

If yes, please explain: ____

When was the problem first noticed ?_______________________ By whom?______________________________

Has your child received previous speech-language-literacy evaluations or therapy?

☐ No ☐ Yes If yes, when/where?____

Speech-Language/Hearing Development

At what age did your child: babble _________ speak first word _________ combine two or three words_________

Please check the appropriate answer to the following statements:

Child kept adding words once he/she began to talk ☐ No ☐ Yes

Child appears to be aware of a speech difficulty. ☐ No ☐ Yes

Child is teased by others about his/her speech. ☐ No ☐ Yes

Child uses gestures when trying to communicate. ☐ No ☐ Yes

Child is able to follow directions without repetition. ☐ No ☐ Yes

Child is able to understand new words easily. ☐ No ☐ Yes

Does child respond to sound? ☐ No ☐ Yes

If yes, how (smiles, turns head, etc.)? ____

Does child jump or startle at loud sounds? ☐ No ☐ Yes

Does child rub, pull on, or complain about his/her ears? ☐ No ☐ Yes

Does child seem confused with directions of sound? ☐ No ☐ Yes

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Would you consider child to be: ❒ Talkative ❒ Average ❒ Quiet

How well is child understood by:

parent/guardian?	❒ Good	❒ Fair	❒ Poor
by other children?	❒ Good	❒ Fair	❒ Poor
non-family members?	❒ Good	❒ Fair	❒ Poor

History of Pregnancy, Delivery, Post-Delivery

Did mother have or use any of the following during pregnancy? If yes, describe:

Infections	❒ No	❒ Yes	________
Toxemia	❒ No	❒ Yes	________
Surgeries	❒ No	❒ Yes	________
Drug/Alcohol	❒ No	❒ Yes	________
Cigarettes	❒ No	❒ Yes	________
Medications	❒ No	❒ Yes	________

Any other information regarding pregnancy ________________________________

____

What was the duration of the pregnancy? ________________________________

What was the child's birth weight? __________ lbs. __________ oz.

Were there any known problems/complications during delivery (e.g., cord around neck, forceps, etc.)?

❒ No ❒ Yes

Explain:____

____

After delivery, did the child have any breathing problems? ❒ No ❒ Yes

Explain:____

____

Was the baby in an incubator? ❒ No ❒ Yes

No. of days: ______________

Were there any sucking or feeding problems? ❒ No ❒ Yes

Explain:____

____

How many days was the baby in the hospital?

____

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Medical History

Has this child ever had:

Encephalitis	❒ No	❒ Yes	Meningitis	❒ No	❒ Yes
Vision Problems	❒ No	❒ Yes	Fever over 103	❒ No	❒ Yes
Draining ears	❒ No	❒ Yes	Ear infections	❒ No	❒ Yes
Ventilation tubes(ears)	❒ No	❒ Yes	Hearing aid	❒ No	❒ Yes
Convulsions/seizures	❒ No	❒ Yes	Loss of consciousness	❒ No	❒ Yes
Lead poisoning	❒ No	❒ Yes	Surgery/hospitalization	❒ No	❒ Yes
Failure to gain weight	❒ No	❒ Yes	Abnormal growth	❒ No	❒ Yes
Allergies	❒ No	❒ Yes	Any medications	❒ No	❒ Yes
Asthma	❒ No	❒ Yes	Congestion	❒ No	❒ Yes
Other serious illness	❒ No	❒ Yes	Head/neck injury	❒ No	❒ Yes

If yes, please explain (for example, age of illness, severity, treatment given, where treatment was provided, etc.)

____

____

____

Have any medical specialists been contacted for the child? ❒ No ❒ Yes

When was your child's last doctor visit? ______________________________

Reason: ______________________________

Are the child's immunizations current? ______________________________

Developmental History

At what age did child: (if unsure, please indicate if any seemed late in developing)

Sit alone, unsupported	________	Crawl	________
Stand alone	________	Feed self with spoon	________
Walk alone	________	Dress/undress	________
Complete toilet training	________		

How would you describe child's general:

coordination?	❒ Poor	❒ Average	❒ Good
activity level?	❒ Low	❒ Medium	❒ High

Describe any behavioral problems that you feel your child exhibits to an excessive degree (e.g., hyperactive, sleeping or eating problems, destructive, temper tantrums, unusual fears, etc.): ______________________________

____

Types of activities your child enjoys: ______________________________

____

Types of activities your child avoids: ______________________________

____

Additional comments regarding child's development: ______________________________

____

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Family History

Parents/Guardians: **Marital Status:** ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Mother	***Father***
Name:__________ Age: ____	Name:__________ Age:____
Address: __________	Address: __________
City: ______ ST:___ ZIP:____	City:______ ST: ___ ZIP: ____
Occupation:__________	Occupation: __________
H. Ph:______ W. Ph:______	H. Ph.: ______W. Ph.______
Cell Ph: __________	Cell Ph:__________
Email:__________	Email:__________

Siblings: Name

Name	M/F	Age	Lives with Child?
__________	___	___	☐ No ☐ Yes
__________	___	___	☐ No ☐ Yes
__________	___	___	☐ No ☐ Yes
__________	___	___	☐ No ☐ Yes
__________	___	___	☐ No ☐ Yes
__________	___	___	☐ No ☐ Yes

Please list all people who live with the child:

__________ __________
__________ __________
__________ __________

Does anyone in the child's family have developmental delays, speech problems, hearing problems or special needs?
☐ No ☐ Yes Explain: __________

____

Day Care and School History
Does your child attend school or day care? ☐ No ☐ Yes
If yes, school name/grade:__________
Have teachers reported any concerns? ☐ No ☐ Yes
If yes, explain: __________

____

Additional Information: Please state any additional information that would assist us in evaluating your child:

____
____
____

__________ __________
Person completing this form Relationship

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