

**UK COMMUNICATION DISORDERS ACADEMIC CLINIC  
CHILD CASE HISTORY FORM**

**GENERAL INFORMATION**

Child's Name:	Today's Date:
Birthdate:	
Child's age:	
Address:	
Mother's Name:	Father's Name:
Phone:	Phone:

Referred by: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Describe your reason for visiting our clinic:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Children in the Family:  
Name:

Age:

\_\_\_\_\_

\_\_\_\_\_

Describe any speech, hearing or language problems in the family:

\_\_\_\_\_

\_\_\_\_\_

Is there a language other than English spoken in the home? Yes No

If yes, which one? \_\_\_\_\_

Does the child speak the language? Yes No

Does the child understand the language? Yes No

Who speaks the language? \_\_\_\_\_

Which language does the child prefer to speak at home? \_\_\_\_\_

**BIRTH HISTORY**

Was there anything unusual about the pregnancy or birth? Yes No

If yes, please describe.

\_\_\_\_\_

\_\_\_\_\_

What was mother's age when the child was born? \_\_\_\_\_  
 How many months was the pregnancy? \_\_\_\_\_  
 How much did the child weight at birth? \_\_\_\_\_  
 Were there any feeding Problems at Birth? \_\_\_\_\_

**MEDICAL HISTORY**

Has your child had any of the following?

ear infections	adenoidectomy
ear tubes	tonsillectomy
hearing problems	breathing problems
allergies	sleeping problems
colds	whooping cough
strep throat	seizures
tonsillitis	head injury
Vision problems	Other

Other serious injury/surgery:

\_\_\_\_\_

Is your child currently (or recently) under a physician's care? Yes No  
 If yes, why? \_\_\_\_\_  
 \_\_\_\_\_

Please list any medications your child takes regularly:

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

Any food allergies? Yes No

If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

At what age did your child:

Crawl:	Completely Toilet Trained:
Sit alone:	Dress Self:
Stand:	Feed Self:
Walk:	

Does your child have any feeding or swallowing problems? Yes No

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

Does your child use any assistive equipment (hearing aids, wheelchair, etc.):

\_\_\_\_\_

## **SPEECH, HEARING AND LANGUAGE**

At what age did your child:

Babble:
Use first words:
Put two words together:
Talk in short sentences:

Does your child use words to make his/her needs known? Yes No

Does your child use gestures or pointing to make his/her needs known? Yes No

Does your child understand what you are saying? Yes No

Does your child follow simple directions? Yes No

Does your child correctly to yes/no questions? Yes No

Does your child respond correctly to who/what/where/when/why questions? Yes No

How does your child currently communicate with you:

body language

sounds (vowels, grunting)

words (shoe, doggy, up)

2 to 4 word sentences

sentences longer than four words

other \_\_\_\_\_

Has he/she ever had a speech evaluation/screening? Yes No

If yes, where and when?

---

What were you told?

---

Has he/she ever had a hearing evaluation/screening? Yes No

If yes, where and when?

---

What were you told?

---

Has your child ever had speech therapy? Yes No

If yes, where and when?

---

What was he/she working on?

---

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? Yes No

If yes, please describe.

---

Is your child aware of, or frustrated by, any speech/language difficulties? Yes No

