



ADVANTIS

Specialized Speech & Learning Center

Child Case History

GENERAL INFORMATION

Child Name:	DOB:	Gender: M F
Address:		
City:	State:	ZIP:
Home Phone:	Cell Phone:	

Mother's Name: _____ Age: _____

Mother's Occupation: _____ Work Phone: _____

Father's Name: _____ Age: _____

Father's Occupation: _____ Work Phone: _____

Does the child live with both parents? Y N

If no, with whom does the child live? _____

Siblings: Y N

Sibling #1: _____ Age: _____

Sibling #2: _____ Age: _____

Sibling #3: _____ Age: _____

Sibling #4: _____ Age: _____

Referred By: _____ Phone: _____

Physician: _____ Phone: _____

Please provide copies the most recent report for the Doctor, agency or school listed above.

Other specialists who have seen the child: _____

Address: _____ Phone: _____

What were the other specialists' conclusions and/or recommendations? _____

What language (s) does the child speak? _____

How does the child usually communicate?

Gestures

Sign Language

Single Words

Short Phrases

Sentences

Describe the child's speech-language or hearing problem. _____

When was the problem first noticed? _____

Who first noticed the problem? _____

What do you think may have caused the problem? _____

Since you first noticed the problem, what changes have you observed in your child's speech,
language, or hearing? _____

Is the child aware of the problem? Y N

What have you done to help your child with the problem? _____

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

PRENATAL AND BIRTH HISTORY

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

Length of pregnancy: _____ Length of labor: _____

Child's general condition: _____ Birth weight: _____

Circle type of delivery: head first feet first breech Cesarean

Were forceps used? _____

Child's length of stay in hospital: _____

Describe any unusual conditions that may have affected the pregnancy or birth. _____

MEDICAL HISTORY:

Child's general health is: **Good Fair Poor**

Provide the approximate ages at which the child experienced the following illnesses and conditions.

Adenoidectomy _____	Asthma _____	Allergies _____
Chicken pox _____	Colds _____	Convulsions _____
Croup _____	Draining ear _____	Dizziness _____
Ear infections _____	Epilepsy _____	Encephalitis _____
German measles _____	Headaches _____	Hearing loss _____
Heart problems _____	High fever _____	Influenza _____
Measles _____	Mastoiditis _____	Meningitis _____
Mumps _____	Noise Exposure _____	Pneumonia _____
Seizures _____	Sinusitis _____	Tinnitus _____
Tonsillitis _____	Tonsillectomy _____	Visual Problems _____
Other _____	Glasses _____	

List child's current medications. _____

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

DEVELOPMENTAL HISTORY

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 the child have any motor difficulty, such as walking, running, or participating in other activities which require small or large muscle coordination? _____

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

Does the child:

Respond to any sounds? **Y** **N**

Respond to the sound of the telephone bell? **Y** **N**

Respond to the sound of human voices? **Y** **N**

Respond to loud sounds only? **Y** **N**

Respond to sounds inconsistently? **Y** **N**

Seem to ignore sounds willfully? **Y** **N**

Do you suspect any problems with hearing? **Y** **N**

GENERAL BEHAVIOR

Does the child eat well? **Y** **N** Sleep well? **Y** **N**

How does the child interact with other family members? _____

Is the child: attentive _____ extremely active _____ restless _____

Does the child bang his/her head, rock, or spin? **Y** **N**

Does the child play by him/herself? **Y** **N**

How does the child interact with other children? _____

Does the child lose his/her temper? **Y** **N**

With whom does the child spend most of the day? _____

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). _____

Please add any additional information you feel might be helpful in the evaluation or treatment of the child's problem. _____

Person completing the form: _____

Relationship to the child: _____

Signed: _____ Date: _____