

## Robyn Merkel-Walsh MA, CCC-SLP

### Case History Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ Age: \_\_\_\_\_  
\_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
\_\_\_\_\_ Other Phone: \_\_\_\_\_  
Referral Source: \_\_\_\_\_

What is your concern about your child's communication abilities? Has the condition changed in the past six months?

School Placement: \_\_\_\_\_  
Classification: \_\_\_\_\_

Current Services:

PT \_\_\_\_\_ OT: \_\_\_\_\_ ST: \_\_\_\_\_

Pediatrician's Name and Address (to mail report):

## I. FAMILY HISTORY

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Place of Birth \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Age \_\_\_\_\_  
 Occupation \_\_\_\_\_ Place of Birth \_\_\_\_\_

## 1. Who lives in the home?

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
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## 2. What languages are spoken at home?

## 3. Is there any history of speech or language problems in the family? If yes, please describe.

## 4. Is there any history of hearing problems in the family? If yes, please describe.

## 5. Describe any significant family medical, learning or emotional history.

## 6. Have any other specialists seen the child? If so, what were the other specialists' conclusions or recommendations?

## II. BIRTH HISTORY

1. Length of pregnancy: \_\_\_\_\_ weeks. Did you smoke cigarettes, drink alcoholic beverages, take medication or use drugs during your pregnancy?

2. Were there any complications during pregnancy? If so, please explain.
  
3. Were there any problems during labor and delivery? If so, please explain. Was delivery vaginal or by caesarean section?
  
4. What was the child's weight and general condition at birth?

### III. MEDICAL HISTORY

1. Has your child been hospitalized? If so, include age, reason and length of stay.
  
2. History of illness, including age.
  
3. History of accidents, including age.
  
4. How would you describe your child's general health?
  
5. Does your child have allergies or frequent colds? If so, describe.
  
6. Is your child currently under a doctor's care? Is s/he taking any medication? If so, what kind and why?
  
7. Has your child's hearing been tested? If so, when and what are the results?

8. Does your child have a history of middle ear infections? If so, include when and how often. Has s/he required ear surgery?
9. Has your child's vision been tested? What were the results?

#### IV. DEVELOPMENTAL HISTORY

1. At what age did your child:
 

roll over_____	stand independently_____
sit independently_____	walk independently_____
crawl_____	toilet train_____
finger feed_____	self-feed with utensils_____
First vocalize_____	Babble_____
Say first words_____	Combine words_____
Talk in complete sentences_____	

#### Oral/Feeding Habits

2. Has your child had any feeding difficulties? (e.g., drooling, swallowing). Does s/he avoid any foods?
3. When did your child wean from a bottle?
4. Did your child use a sippy cup for more than 3-6 months?
5. Does your child use a straw to drink liquids?
6. When did your child stop sucking his/her thumb or digits?
7. Did your child use a pacifier? If so, for how long?
8. Does your child grind his teeth/ or tense his jaw?
9. Does your child exhibit open mouth posture and mouth breath?

10. Is your child sensitive to textures?
11. Is your child sensitive to sounds?
12. Is your child sensitive to smell?
13. Is your child tactile defensive?
14. Does your child exhibit any self stimulatory behaviors? If so describe.
15. Which hand does your child use primarily?
16. Does your child seem to have any balance or coordination difficulties? If so, please describe.
17. How is your child's sleeping patterns?
18. How does your child currently communicate his/her wants and needs?
19. How clear is your child's speech ?
20. How well does your child understand what is being said to him/her?

## V. SOCIAL HISTORY

1. How would you describe your child's personality?

2. Describe your child's socialization skills with family and familiar people.
3. How does your child react to unfamiliar people and/or situations?
4. How does your child interact with other children?
5. What are your child's favorite activities/hobbies?
6. Describe your child's activity level.

VII. Is there any other information about your child that would be helpful to us in evaluating his/her communication abilities? Please explain.