Georgia State University Speech-Language-Hearing Clinic
Communication Sciences and Disorders Program
Georgia State University
P O Box 3979
Atlanta, GA 30302-3979
(404) 413-8044

Preschool Child Case History (0 - 5 years)

Please answer all questions as completely as possible. The information you provide is very helpful in planning your child's evaluation/therapy.

Name of child: _________________________________ Nickname: _________________Date:________

Date of birth: __________________ Age: ______ Ethnicity: ________________ Gender: __________

Address: ____

____

Phone: (Home): ____________________ (Work): __________________ (Cell): __________________

Can we contact parent at work? Yes _____ No _____

Do we have permission to leave specific client information and appointment details on your home or cell phone? Yes _____ No _____

Parent(s)/Guardian(s)

Name	Age	Occupation	Phone

Other children in the family:

Name	Age	Name	Age

Language(s) the child speaks: Primary ________________________ Secondary ____________________

Referred to Clinic by: ____

Emergency contact: Name _______________________________ Phone: __________________________

Name of person completing this form: ____

Relationship: ____

Speech and Language History

1. Why are you seeking an evaluation at our Clinic?

2. Please describe your child's communication difficulty and any related problems.

3. When was your child's communication difficulty first noticed and by whom?

4. What do you think caused your child's communication difficulty?

5. Does your child's communication difficulty ever become worse? If yes, in what situations?

6. Did your child's speech and language development ever seem to stop for a period of time? If yes, please explain.

7. What steps have you taken to try to improve your child's communication difficulty?

8. Have you consulted your child's pediatrician, neurologist, psychologist, developmental pediatrician, or other specialist about your concerns? If yes, what was recommended?

9. Has your child ever received speech/language services? If yes, please provide information below.

Dates of Service	Type of Service	Name of Speech-Language Pathologist/Facility/School

10. What were the results of the service(s)?

11. Indicate the age at which your child:
    - Began to babble ________
    - Said first word ________ What were they? ______________________
    - Had a vocabulary of 50 words ________
    - Began to say two-word sentences ________
    - Began to say complete sentences ________
    - Began asking questions ________

12. How long are your child's typical sentences (Number of words)? _____________________

    Example: ____

13. How often do **you** understand what your child says?
    _____ Always _____ Most of the time _____ Frequently
    _____ Occasionally _____ Rarely _____ Never

14. How often do **relatives and friends** of the family understand what your child says?
    _____ Always _____ Most of the time _____ Frequently
    _____ Occasionally _____ Rarely _____ Never

15. How often does **your child** understand what others say to him/her?
    _____ Always _____ Most of the time _____ Frequently
    _____ Occasionally _____ Rarely _____ Never

Medical and Developmental History

1. Were there any complications before or during the birth of your child? If yes, please describe.

   ____

2. APGAR score _________
3. Your child’s birth weight ___________
4. Were any medications taken during pregnancy or delivery? If yes, please explain.

   ____

5. Has your child ever been hospitalized? If yes, please complete the information below.

Reason for Hospitalization	Date(s)	Length of Stay

6. If yes, were there any changes in your child’s speech and language following hospitalization?

   ____

7. List your child's physicians' names, specialty areas, facility names, and phone numbers.

Name	Specialty	Facility	Phone Number

8. Describe your child's current health. Excellent ______ Good ______ Fair _______ Poor _______
If "fair" or "poor," please explain.
____
____

9. Did a medical condition or event lead to your child's communication difficulty? Yes____ No ____
If yes, provide event and date of onset. ____
____

10. Is your child currently taking any medications? If yes, please list name and purpose of medication.
____
____

11. Does your child have a history of ear infections? Yes ____ No ____
How many per year/when? ____
How were they treated? ____

12. Were PE tubes ever recommended or inserted? If yes, please explain.
____

13. Please check all illnesses/conditions your child has or has had in the past:

	Yes		Yes		Yes
Allergies (food, latex, seasonal)		Head injury		Mental health disorder (anxiety, depression, etc.)	
Asthma		Hearing impairment		Mumps	
Bronchitis		Heart problems		Muscle weakness	
Chronic colds		High fever		Paralysis	
Chronic laryngitis		HIV positive/AIDS		Pneumonia	
Chronic sinus infections		Hepatitis A		Seizures	
Cleft palate		Hepatitis B		Sickle cell	
Dental problems		Hepatitis C		Surgery	
Diabetes		Immune disorder		Swallowing difficulty	
Difficulty chewing		Impaired coordination/balance		Tremors/twitching	
Encephalitis		Loss of consciousness		Visual impairment	
German measles		Meningitis		Other	

If your child has experienced any of the difficulties listed above, please explain.
____
____

14. Has your child been diagnosed with the following?

	Yes		Yes
ADD or ADHD		Down Syndrome	
Auditory Processing Disorder		Developmental Delay	
Autism Spectrum Disorder (Including diagnoses of Asperger's and PDD-NOS)		Intellectual disability/ Cognitive Impairment	
Behavioral Disorder		Mental health disorder (anxiety, depression, etc.)	
Cerebral Palsy		Sensory Integration Disorder	

If yes, please explain.

____

____

15. Has your child ever received physical or occupational therapy? If yes, provide information below.

Type of Service Dates of Service Name of Therapist/Facility

____

____

16. What was the reason for the therapy and the result?

____

____

17. Indicate the ages at which your child learned to:

Crawl_______________________ Jump ______________________________
Sit up_______________________ Drink from a cup ______________________
Walk _______________________ Eat with a spoon ______________________
Climb stairs _________________ Scribble on paper ______________________
Throw a ball ________________ Turn pages of a book ___________________

18. What age was your child bladder trained? __________________
19. What age was your child bowel trained? ___________________
20. Does your child suck his/her thumb? ______________________

Educational and Social History

1. Is your child enrolled in a preschool or playgroup? If yes, describe the type of preschool or group.

____

____

2. Does your child's teacher have any concerns about your child's communication, academic performance, or behavior? If yes, please describe.

____

____

3. How does your child interact with other children?

____

____

4. What are your child's favorite activities, toys, and interests?

____

____

5. What things does your child do particularly well?

____

____

Family History

1. Does anyone in your family have a speech, language, or hearing impairment? If yes, please explain.

____

____

2. Was anyone in your family a "late talker?" If yes, please explain.

____

____

3. Do you have any concerns regarding your child's behavior? If yes, please describe.

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Additional Comments

Please provide any additional information which might be helpful in evaluating your child's communication skills.

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Please return this form to:

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