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

School-Age Child Case History (6 – 17 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 been 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 the following:

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

   _____

   _____

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

    _____

    _____

11. Indicate the age at which your child:

Began to babble _____
Said first words _____ 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

16. Does your child have difficulty:

	Yes		Yes		Yes
Defining words		Answering questions		Waiting for a turn to talk	
Learning new words		Asking for help		Following directions	
Producing grammatically correct sentences		Clarifying what he/she has said		Following the rules of the classroom	
Producing sounds correctly		Reading		Talking to groups of people	
Speaking fluently without repeating words or sounds		Spelling		Talking on the phone	
Speaking loud enough for others to hear		Writing		Thinking before speaking	
Talking about past or future events		Explaining information clearly		Organizing ideas	
Telling a story		Maintaining a conversation		Recalling information	

If yes, please explain.

_____

_____

Medical and Developmental History

1. Were there any complications before or during the birth of your child? 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 that led 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? 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 History

1. Please list the name of the school that your child attends.

Name: _____ Grade _____

2. Describe your child's performance in school?

Excellent_____ Above Average_____ Average_____ Below Average_____ Poor_____

3. What are your child's strengths in school?

_____

4. What are your child's weaknesses in school?

_____

5. Does your child's teacher have any concerns about your child's communication, behavioral, or academic performance? Please describe.

_____

_____

6. Has your child ever repeated a grade in school? _____

_____

7. What is your child's favorite subject in school? _____
8. What is your child's least favorite subject? _____
9. Does your child receive any special services at school? (e.g., tutoring in reading, learning disability services, etc.) If yes, please explain.

_____

_____

10. How many minutes or hours per evening does your child spend on homework? _____
11. How much time does your child spend watching TV or playing, video or computer games per day?

_____

Social History

1. How does your child interact with other children?

_____

2. Do other children ever tease your child about his/her communication difficulty? Please explain.

_____

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

_____

4. What things does your child do particularly well?

_____

Family History

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

_____

_____

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

_____

_____

3. How does your child interact with his/her brothers and sisters? *(If applicable)*

_____

4. Do you have any concerns about your child's behavior? Please describe.

_____

_____

Additional Comments

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

_____

_____

_____

_____

Please return this form to:

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