SUSAN COHN & ASSOCIATES

CASE HISTORY

Thank you for taking the time to complete this form. A thorough case history is a very important piece of the speech-language evaluation process. Please answer the following questions as accurately as possible. **Any questions that do not pertain to your child or the answer is unknown, please write '*N/A' or 'unknown.'***

Today's Date: ______________
Person completing this form: ____
Relationship to patient:____
Child's Name: ____
Parents: ____
Child's primary care physician:____
Child's Date of Birth: ________________ Age: ____
Phone Work: __________________________ Home: ______________________
Address: ____
Siblings: ________________________ Age: ________________________
________________________ Age: ________________________
________________________ Age: ________________________
________________________ Age: ________________________

Referral Source:
____

Diagnosis (if known):
____

Medications:
____

Allergies:
____

Please answer the following:

Is English your child's first language? YES NO
If your child is learning another language or another language is being spoken in the home, please specify:
____
____
____

Is your child in a day care, infant program, preschool or school? YES NO
If so, where, what grade and how many days per week? ______________________________
____

Describe your child's speech-language problem.

____

When did you first notice the problem?

____

Does anyone in your family have a speech-language problem? Learning difficulties? YES NO
If so, whom and please describe.

____

Would you describe your child as a quiet infant? YES NO

Did your child babble? YES NO At what age? _______________

Did your child use a variety of sounds when babbling? YES NO
Examples:

____

When did your child say first words? _______________ Put two words together? _______________

What were your child's first words? ____

Once your child started to use words, did the development of new words continue? YES NO

How many words does your child use now?
Please circle one: 0-20 20-50 50-100 100-150 150-200 200-300 300+

Does your child produce phrases and sentences? YES NO
Please circle one: 2-word 3-word 4-word 5-word more

Does your child have difficulty making some consonant speech sounds? YES NO
If so, please list them: ____
Does your child prefer to communicate using gestures or by pointing? _______________

Does your child ever become frustrated when trying to speak or communicate his/her needs?
YES NO
If yes, please explain____
What helps your child reduce his/her frustration? _______________________________

Does your child have a history of using words once then never again? YES NO

Does your child play and communicate well with family? YES NO

Can others outside of the family understand your child when he/she speaks? YES NO

When did your child: smile? __________ sit?__________ roll over?__________
crawl?__________ walk?__________

Does your child have a history of:
Ear infections? YES NO How often? ______________________________
Allergies? YES NO What kind? ______________________________
Asthma? YES NO How severe? ______________________________

Has your child ever had:
Surgery? YES NO Type and date? ______________________________
Chronic illness? YES NO Type and date? ______________________________
Serious accident? YES NO Type and date? ______________________________

Did you or your spouse have a normal pregnancy, labor, and delivery? YES NO
If not, please explain.

____

____

Was the pregnancy full-term? YES NO
If not, please explain.

____

____

What was your child's condition at birth? ______________________________

Were there any feeding difficulties immediately after birth? YES NO

Did your child have special needs after birth? YES NO

Does your child eat a variety of foods? YES NO
Examples: ______________________________
Is your child a picky eater? YES NO

Does he/she have a preference for a specific type of food or texture (e.g., crunchy, creamy, etc.)

____

When did your child start eating solid food? ______________________________

Did he/she have difficulty moving from liquids to solids? YES NO
If yes, please explain.

____

____

When did your child transition off of a bottle/the breast? ______________________________

Does your child choke or cough often when eating or drinking? YES NO

Does your child overstuff his/her mouth when eating? YES NO

Is he/she a messy eater? YES NO

Is he/she aware or bothered by a messy face? YES NO

Does your child resist face washing? YES NO

Does your child resist tooth brushing? YES NO

Does your child put objects in his/her mouth frequently? YES NO
Examples: ____

Has your child ever sucked his/her thumb or pacifier? YES NO
If yes, for how long? ______________________________

Does your child drool? YES NO

Is your child able to blow soap bubbles or blow out a candle? YES NO

Does your child have difficulty learning motor tasks (e.g., running, jumping, hopping, coloring, holding a spoon)? YES NO

Does your child seem clumsy? YES NO

Does your child seem to imitate speech sounds or words? YES NO

Does your child seem to have difficulty understanding spoken language? YES NO
Can your child follow simple directions? YES NO

Can your child follow complex directions? YES NO

If your child speaks in sentences, does he/she use correct grammar? YES NO

Describe your child's personality?

____

____

What are some of your child's interests/hobbies?

____

____

Do you have concerns with your child's vocal quality, vocal loudness, and/or fluency? YES NO
If yes, please explain.____

Has your child ever had a hearing evaluation? YES NO
Date: ______________________
Results: _____________________

Has your child ever had a previous speech and language evaluation? YES NO
If ***yes***, please provide us with a copy of previous reports.
Date: ______________________
Who completed the evaluation? ____

Has your child ever been enrolled in speech-language therapy? YES NO
If ***yes***, please provide us with previous treatment plan &/or progress note.
Dates: _____________________
Goals:
____
____

Has your child ever been enrolled in physical or occupational therapy? YES NO
Date: _____________________

Is there any information about your child that you feel is important for us to know?
____
____
____
____

Thank You☺