kidSpeak
SPEECH & LANGUAGE SERVICES

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Preschool Case History Form

General Information:

Child's Name:_____ Date of Birth:_____

Gender: M ____ F ____ Diagnosis:_____

Parents' Names:_____

Home Address: _____

City:_____ State:_____ Zip Code:_____

Phone: (H)_____ Cell:_____ Work:_____

Email addresses:_____

Legal Guardian (if other than parent):_____

Please list other members of the household:

Name	Age	Relationship to Child
1.		
2.		
3.		
4.		

** Is there any history of speech/language, gross motor, fine motor, learning, or developmental problems in the immediate family or mother's/father's families: Yes _____ No _____.

If yes, please explain: _____

_____

Medical History:

Length of pregnancy: _____ Complications during pregnancy: Yes____ No____

If yes, please explain: _____

Complications at birth/delivery: Yes_____ No_____ If yes, please explain: _____

_____

In NICU: Yes_____ No_____ If yes, how long: _____

Spit up frequently/acid reflux? Yes_____ No_____ Strong Suck? Yes___ No___

Has your child had any major accidents/illnesses/hospitalizations? Yes_____ No_____

If yes, please explain: _____

_____

Has your child had any ear infections? Yes_____ No_____. How many? _____

Has your child ever received PE tubes? Yes_____ No_____.

Does your child have a history of seizures? Yes_____ No_____.

Has your child ever has tonsil and/or adenoid issues? Yes_____ No_____.

Please list all current medications that your child is taking and what condition they are indicated for: _____

_____

Please list any allergies your child has: _____

_____

Describe your child's sleep pattern: _____

_____

Pediatrician's name/Practice: _____

Pediatrician's phone: _____ fax: _____

Oral Development:

Please indicate (√) if your child does the following:

Uses pacifier/sucks fingers or thumb: _____ Eats table food:_____.

Drinks from an open cup: _____ Drinks from a straw: _____ Uses a spoon/fork: _____.

"Tongue tie" or a short lingual frenulum: _____

Repaired cleft palate or cleft lip:_____

Is your child a picky eater? Yes_____ No ____

If yes, please explain: _____

_____

Does your child gag, choke, or vomit with any foods? Yes_____ No_____.

Do you have any concerns about your child's feeding skills? Yes_____ No_____.

Developmental History:

Please provide the approximate age at which your child began to do the following:

Walk:_____ Use single words:_____

Ask/answer questions:_____

Combine words into phrases/sentences:_____

Engage in conversation:_____

Current Communication:

Does your child…..

_____ repeat sounds, words, or phrases?

_____ understand what you are saying?

_____ retrieve or point to objects on request (e.g., ball, cup)?

_____ follow simple directions (e.g., “get your shoes” or “shut the door”)

_____ respond correctly to yes/no questions?

_____ respond correctly to *what/where/who/when/why* questions?

How does your child communicate at this time? *Please check all that apply*

_____ Sign language

_____ Gestures or Pointing

_____ Sounds/Babbling

_____ Grunting

_____ Single words

_____ 2-3 word phrases

_____ 4+ word sentences

_____ Other

Behavioral characteristics: *please check all that apply*

- □ Cooperative
- □ Attentive
- □ Willing to try new activities
- □ Plays alone for reasonable length of time
- □ Separation difficulties
- □ Easily frustrated/impulsive
- □ Stubborn
- □ Restless
- □ Poor eye contact
- □ Easily distracted/ short attention
- □ Destructive/ aggressive
- □ Withdrawn
- □ Inappropriate behavior
- □ Self-abusive behavior

Educational History:

Child’s current placement: Home____ Daycare_____ Preschool_____

Name of school/ City:_____

If in preschool/daycare, how many days per week & hours per day: _____

_____

Has your child ever been evaluated for or received the following services?

Speech Therapy_____ Occupational Therapy_____ Physical Therapy_____.

Please list all previous and current therapies received:

Where received? *Length/ Dates of Treatment:*

_____

_____

_____

***Current Concerns*:**

Please describe your concerns today: _____

_____

_____

When was the problem first noticed? _____By whom?: _____

What do you hope we can accomplish in therapy? _____

_____

_____

Thank you for your assistance in completing this form.
This information is confidential and will be used strictly for therapeutic purposes.

Person Completing this Form: (please print) _____

Signature: _____ Date: _____

Relationship to Child: _____

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