Pediatric Speech Therapy
(dba Speech Therapy of Forsyth, LLC)
4080 McGinnis Ferry Road - Building 300 Suite 302
Alpharetta, GA 30005
770-410-7719 OFC 770-410-9510 FAX

Buckhead/Midtown
Brookwood Exchange Building
1708 Peachtree Street NW Suite 525
Atlanta, GA 30309

Norcross Location
All Kids First/Connecting Dots
4720 Peachtree Inductrial Blvd Suite 305/301
Norcross, GA 30071

SPEECH-LANGUAGE-HEARING
CASE HISTORY FORM

Identifying and Family Information:

Child's Name:_____ Birthdate:_____ Sex: M___ F___

Father's Name:_____ Daytime Phone:_____

Address:_____ Cell Phone:_____

_____ Email:_____

Mother's Name:_____ Daytime Phone:_____

Address:_____ Cell Phone_____

_____ Email:_____

Doctor's Name:_____ Doctor's Phone:_____

Is your child currently receiving any of the following services and/or Therapies?:

Speech Therapy at another location? Yes____ No_____

If Yes, list the name and contact information for the Speech Therapist:

_____ Phone: _____

Speech Therapy in school? Or thru Babies Can't Wait? Yes____ No_____

If Yes, Please provide our office with a copy of the latest IEP or IFSP

Occupational Therapy? Yes____ No_____

If Yes, list the name and contact information for the Occupational Therapist**:

_____ Phone: _____

Please provide our office with a copy of the latest Occupational Therapy Evaluation and/or latest Report

ABA Therapy? Yes____ No_____

If Yes, list the name and contact information for the ABA Therapist**:

_____ Phone: _____

**Please Note: We find it extremely beneficial to discuss concerns, treatment, diagnosis and test results with collaborating health professional(s) {i.e. your child's Pediatrician, other Therapists and/or any other health provider or teacher(s)} that may provide advantageous information to collaborate with and to assist your child's Therapist in providing Therapy to your child.

Child lives with (check one):

- ☐ Birth parents
- ☐ Adoptive parents
- ☐ Foster Parents
- ☐ Parent and Step-Parent
- ☐ One Parent
- ☐ Other_____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Child's race/ethnic group:

- ☐Caucasian, Non-Hispanic
- ☐Native American
- ☐Hispanic
- ☐Asian or Pacific Islander
- ☐African-American
- ☐Other_____

Is there a language other than English spoken in the home? Yes____ No_____

If yes, which one?_____
Does the child speak the language? Yes____ No_____
Does the child understand the language? Yes____ No_____
Who speaks the language?_____
Which language does the child prefer to speak at home? _____

Speech-Language-Hearing

Do you feel your child has a speech problem? Yes____ No_____

If yes, please describe._____

_____

_____

Do you feel your child has a hearing problem? Yes____ No_____

If yes, please describe._____

_____

_____

Has he/she had a Speech Evaluation/screening? Yes____ No_____

If yes, where and when?_____

What were you told?_____

_____

Has he/she had a Hearing Evaluation/screening? Yes____ No_____

If yes, where and when?_____

What were you told?_____

_____

Has your child ever had Speech Therapy? Yes____ No_____

If yes, where and when?_____

What was he/she working on?_____

_____

Has your Child received any other evaluation or Therapy (Physical Therapy, counseling, Occupational Therapy, vision, ect.)?

If yes, please describe._____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties?_____

_____

What do you see as your child's most difficult problem in the home?_____

What do you see as you child's most difficult problem in school?_____

Birth History

Was there anything unusual about the pregnancy or birth? Yes____ No_____

If yes, please describe._____

How old was the mother when the child was born?_____

Was the mother sick during the pregnancy? Yes____ No_____

If yes, please describe. _____

How many months was the pregnancy?_____

Did the child go home with his/her mother from the hospital? Yes____ No_____

If the child stayed at the hospital, please describe why and how long._____

_____

_____

Medical History

Has your child had any of the following?

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Breathing difficulties
- ☐ Chicken pox
- ☐ Colds
- ☐ Ear infections How often? _____
- ☐ Ear tubes
- ☐ Encephalitis
- ☐ Flu
- ☐ Head injury
- ☐ High fevers
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Sinusitis
- ☐ Sleeping difficulties
- ☐ Thumb/finger sucking
- ☐ Tonsillectomy
- ☐ Tonsillitis
- ☐ Vision problems

Other serious injury/surgery:_____

Is your child currently (or recently) under a physician's care? Yes____ No_____

If yes, why?_____

Please list any medications your child takes regularly:_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____sat alone
_____babbled
_____put two words together
_____walked
_____ grasped crayon/pencil
_____said first words
_____spoke in short sentences
_____toilet trained

Does your child…

- ☐ Choke on food or liquids
- ☐ Currently put toys/objects in his/her mouth
- ☐ Brush his/her teeth and/or allow brushing

Current: Speech-Language-Hearing

Does your child… (check the box for YES)

- ☐ Repeat sounds, words or phrases over and over?
- ☐ Understand what you are saying?
- ☐ Retrieve/point to common objects upon request (ball, cup, shoe, ect.)?
- ☐ Follow simple directions ("Shut the door")?
- ☐ Respond correctly to yes/no questions?
- ☐ Respond correctly to who/what/when/where/why questions?
- ☐ Is your child able to repeat sounds with the letter P (example "pa pa")
- ☐ Is your child able to repeat sounds with the letter B (example "ba ba")
- ☐ Is your child able to repeat sounds with the letter M (example "ma ma")
- ☐ Is your child able to repeat sounds with the letter T (example "ta ta")
- ☐ Is your child able to repeat sounds with the letter D (example "da da")
- ☐ Is your child able to repeat sounds with the letter G (example "ga ga")
- ☐ Is your child able to repeat sounds with the letter K (example "ka ka")

Your child currently communicates using…

- ☐ Body language.
- ☐ Sounds (vowels, grunting).
- ☐ Words (shoe, doggy, up).
- ☐ 2 to 4 word sentences longer than four words.
- ☐ Other_____.

Behavioral Characteristics:

- ☐ **Cooperative**
- ☐ **Attentive**
- ☐ **Willing to try new activities**
- ☐ **Plays alone for reasonable length of time**
- ☐ **Separation difficulties**
- ☐ **Easily frustrated/impulsive**
- ☐ **Stubborn**
- ☐ **Restless**
- ☐ **Poor eve contact**
- ☐ **Easily distracted/short attention**

Current: Speech-Language-Hearing

Behavioral Characteristics (continued):

- **Destructive/aggressive**
- **Withdrawn**
- **Inappropriate behavior**
- **Self-abusive behavior**

School History

If your child is in school, please answer the following:

Name of school and grade in school:_____
_____

Does your child have an IEP? Yes____ No____ (**as previously requested, please provide our office with a copy of the *current* IEP)

Teacher's name:_____

Has your child repeated a grade?_____
_____

What are your child's strengths and/or best subjects?_____
_____

Is your child having difficulty with any subjects?_____
_____

Is your child receiving help in any subjects?_____
_____

Additional Comments:

_____
_____
_____
_____
_____
_____
_____
_____