Speech Therapy of Forsyth, LLC
Teaching Children. Coaching Parents.

Speech Therapy of Forsyth, LLC
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Speech – Language

Case History Information

Welcome to our clinic! We want to thoroughly understand your child. Speech & Language are like the flowers on a plant… all systems have to be working well to make it happen! So, please, feel free to be very detailed answering the questions below.

Identifying and Family Information:

Child's Name:_____ Birthdate:_____ Sex: M____ F ____

Insurance: _____ Member ID: _____

Phone Number on the back of the card: _____ Responsible Party: Name and DOB:_____

Is there a secondary insurance or Medicaid insurance? If yes, please provide name _____

Mother's Name:_____ Father's Name: _____

Address: _____ Father's Address:_____

_____ _____

Phone:_____ Father's Phone: _____

Email: _____ Father's Email: _____

Pediatrician's Name:_____ Pediatrician'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 OT: _____ 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 : _____ Phone:_____

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 in the home?_____
Which language does the child prefer to speak at home? _____

Speech-Language-Hearing

Please describe your primary concern regarding your child's speech & language development.

_____

_____

_____

When and where was your child's last hearing test?

_____

When was your child's last medical check-up?

_____

Do you feel your child has a speech 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 your child ever received 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

Length of pregnancy _____ Were there any prenatal complications? Yes____ No_____

If yes, please describe._____ Birth weight _____

Were there any neonatal complications? Yes____ No_____

If yes, please describe._____

Was child able to nurse? Yes____ No_____

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

Early Developmental Milestones

Please indicate the age (in months) when your child:

Sat _____ Stood _____ Walked _____

1st Word _____ 2nd Word _____ Toilet Trained _____

Feeding

Preferred foods _____

Foods avoided _____

Dental development or concerns _____

Check the utensils your child uses independently: Fork _____ Spoon _____ Cup _____ Straw _____

Does your child chokes easily? Yes____ No_____

Does your child pocket food in his/her cheek? Yes____ No_____

Does your child use his/her tongue to swipe food from inner cheek? Yes____ No____ From lips? Yes_____ No____

Does your child imitate : Mouth open? Yes___ No___ Tongue out? Yes____ No____

Speech

Babbling: Yes ___ No ___ Jargon: Yes ___ No ___ Real words: Yes ___ No ___

Mom understands _____% Dad understands _____% Stranger understands _____%

Simple errors _____

_____

Frustration shown by _____

_____

Language

Please indicate, does your child:

Follows 1st step commands Yes____ No_____

Follows 2nd step commands Yes____ No_____

Need extra time to understand Yes____ No_____

Does your child have less than five spoken words (vocabulary) ? if yes, what words is he/she using on a regular basis:

_____

What is the average number of words used per utterance _____

How does your child communicate what he/she needs or wants? _____

How does your child show he/she is frustrated? _____

Fluency

Please indicate, does your child:

Stutter Yes____ No_____

Repeats sounds or words Yes____ No_____

Gets stuck on a sound Yes____ No_____

Prolongs sounds Yes____ No_____

Setting where stuttering is worse _____

Setting where stuttering is better _____

Shows frustration by _____

Family history of stuttering? Yes____ No_____ who? _____

Voice

Please indicate information regarding your child's voice:

Normal voice Yes____ No_____

Too loud Yes____ No_____ Too quiet Yes____ No_____

Too high Yes____ No_____ Too low Yes____ No_____

Hoarse Yes____ No_____

Medical History

Illnesses _____

Accidents _____

Surgeries _____

Emotional trauma _____

Medications _____

Allergies _____

Specialists _____

Diagnoses _____

Current quality of sleep (on a scale of 1-10 with 10 the highest) _____

Current quality of food intake (on a scale of 1-10 with 10 the highest) _____

Social/Emotional States

Who is caring for your child during the day ?_____

Does your child have access to other children ? _____

Favorite activities_____

Favorite toy(s) ____ _____

How does your child show emotional frustration ? _____

Check all that apply to your child:

Social
Plays alone
Playful
Cautious
Cooperative
Defiant
Calm
Distractible
Alert
Hyperactive
Takes turns
Has separation anxiety
Curious
anxiety
Easily frustrated
Aggressive
Self harms
Withdrawn
Affectionate
Has meltdowns
Pretend play
Plays w/toys
Easily overwhelmed
Like to organize toys
Likes to line up toys in order
Overwhelmed by _____

School

Current School – Daycare – Preschool : _____

Virtual Yes____ No_____

In person Yes____ No_____

School Schedule : Attends School on what days: _____

School times: _____

Does your child have an IEP ? Yes____ No_____ What services does your child receive in school: SP ___ OT ___ PT ___

Additional Accommodations? _____

Teacher_____ Phone _____

School Previously attended: _____

Therapies

Current Therapies outside of School:

Occupational Therapy: Schedule Days/Times: _____
Speech Therapy: Schedule Days/Times: _____
ABA Therapy: Schedule Days/Times: _____
Other Therapy: Schedule Days/Times: _____

Please have current reports from each therapist FAXED to us at 770-410-9510 before your evaluation date.

Has your child received other therapies in the past ?_____

Does your child exhibit any behaviors that are confusing? Behavior often indicate a child's need to communicate, please describe in detail:

_____
_____
_____
_____

What else can you share that would help us to better understand your child?

_____
_____