Tiny Voice Therapy Services

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Case History Form

Child's name _____ Today's date_____
Parents_____ Child's Date of Birth _____
Phone (work/cell) _____ Age _____
(home) _____
Email address_____
Siblings: _____ Age_____
_____ Age_____
_____ Age_____
_____ Age_____
Diagnosis? _____
Medications?_____
Primary Home Language _____
Is your child in a day care, infant program, preschool, or school? If so, where, what grade, and how many days per week? _____
_____

Please answer the following:

1. Describe your concerns: _____
   _____
   _____
2. When did you first notice the problem? _____
   _____
3. Is there a family history of speech-language disorders? Please describe: _____
   _____
   _____
4. Would you describe your child as a quiet infant? _____
5. Did your child babble? At what age? _____
6. Did you child use a variety of sounds when babbling? Examples: _____
   _____
7. When did your child say first words? _____ What were the first words?_____
   _____
8. When did your child combine two words?_____
9. How many words does your child use now?
   0-20 20-50 50-100 100-150 150-200 200-300 300+
10. Does your child produce phrases and sentences?
    2-word 3-word 4-word 5-word more
11. Does your child have difficulty making some consonant/speech sounds? If so, please list them:_____
12. Does your child prefer to communicate by using gestures or by pointing?_____
13. Does your child ever become frustrated when trying to speak or communicate his/her needs?_____ Please explain:_____

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What helps your child reduce frustration?_____

14. Does your child have a history of using words once and never again?_____
15. Does your child play and communicate well with friends and family?_____
16. Can others outside the family understand your child when he/she speaks?_____
17. When did your child: crawl_____ walk_____
18. Does your child have a history of:
    a. Ear infections_____ How often?_____
    b. Allergies_____ What kind?_____
    c. Asthma_____ How severe?_____
19. Has your child ever had:
    a. Surgery_____ Type and date_____
    b. Chronic illness_____ Type and date_____
    c. Serious accident_____ Type and date_____
20. Did you have a normal pregnancy and delivery? Please explain:_____
    _____
21. Was the pregnancy full term?_____
22. What was your child's condition at birth?_____
23. Were there any feeding difficulties immediately after birth?_____
    _____
24. Did your child have any special needs after birth?_____
    _____
25. Did your child eat a variety of foods?_____ Examples:_____
    _____
26. Does he/she avoid any specific type of food or texture? _____
    _____
27. When did your child start eating solid foods?_____

Please check yes or no for the following:

	Yes	No
Does your child drink from a cup?		
Did he/she have difficulty moving from liquids to solids?		
Does your child choke or cough often when eating or drinking?		
Does your child overstuff his/her mouth when eating?		
Is he/she a messy eater?		
Is he/she a neat eater?		
Is he/she bothered by a messy face?		
Does your child resist face washing?		
Does your child resist tooth brushing?		
Does your child put objects in his/her mouth frequently?	Examples:	

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	Yes	No
Does your child suck his/her thumb or use a pacifier?		
Does your child drool?		
Can your child blow soap bubbles or blow out a candle?		
Does your child have difficulty learning motor tasks? (e.g., running, jumping, holding a spoon)		
Does your child seem clumsy?		
Can your child follow simple directions?		
Can your child follow complex directions?		
If your child speaks in sentences, does he/she use correct grammar?	Examples:	Examples:
Does he/she use first and second pronouns (I, me, my, you, your, yours)		
Does your child imitate words or actions?		
Does he/she imitate more single words or phrases, or both?		
Does he/she generate new word combinations he/she heard and memorized?		
Does your child ever use the right phrase but in the wrong situation (*please* instead of *thank you*, *hi* instead of *bye*)		
Does your child request help when needed?	How?	
Does it ever seem like your child is not attending to your words (selective listening)?		
Does your child comment on environmental noises (cars, airplanes)?		
Does your child prefer organization or routine?		

28. How would you describe your child's memory? Poor average amazing
29. Does your child have any strong interest? (e.g., trains, blocks, dolls)_____
    _____
30. Has your child ever had a hearing evaluation? Date: _____ Results:_____
    _____
31. Has your child had a previous speech and language evaluation? Date: _____
32. Has your child ever been enrolled in speech-language therapy? Dates:_____
    Goals:_____

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33. Has your child ever been enrolled in physical or occupational therapy? Dates:_____
    Goals:_____
34. Is there any other information about your child that you feel is important for us to know?_____
    _____
    _____
    _____
    _____

**Please provide copies of any pertinent assessments, reports, Individualized Education Plans, and/or records prior to your child's first appointment. THANK YOU ☺