We play
Therapeutic Play Center

Case History Form

Identifying and Family Information

Child's Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Parent's Names: _____

Siblings / Ages: _____

Pediatrician: _____

Daytime Phone: _____ Cell Phone: _____ Email: _____

Address, City, State & Zip: _____

Language Usage

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? _____

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 ever had a speech or hearing evaluation/screening? ☐ No ☐ Yes, Speech ☐ Yes, Hearing

If yes, when and where? _____

What were you told? _____

_____

Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, when and where? _____

What was he/she working on? _____

_____

Has your child ever received any other evaluation or therapy? (physical therapy, counseling, occupational therapy, vision, etc.)? □ Yes □ No

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? At school? _____

_____

Birth History

Was there anything unusual about the pregnancy or birth? □ Yes □ No

If yes, please describe. _____

_____

Was the mother sick during 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	□ Encephalitis	□ Seizures	□ Allergies	□ Ear Tubes
□ Flu	□ Sinusitis	□ Breathing Difficulties	□ Chicken Pox	□ Scarlet Fever
□ High Fevers	□ Thumb/Finger Sucking Habit	□ Colds	□ Measles	□ Reflux
□ Tonsillectomy	□ Ear Infections How Often?	□ Meningitis	□ Tonsilitis	□ Head Injury

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 milestones:

_____Sat Alone	_____put two words together	_____grasped crayon/pencil	_____spoke in short sentences
_____Babbled	_____walked	_____said first words	_____toilet trained

Does your child…

□ choke on food or liquids?	□ avoid certain foods/textures?	□ enjoy birthday parties?
□ currently put toys/objects in his/her mouth?	□ enjoy outings?	□ dislike a change in routine?
□ brush his/her teeth and/or allow brushing?		

Current Speech-Language-Hearing

Does your child…

□ repeat sounds, words or phrases over and over?	□ understand what you are saying?
□ retrieve/point to common objects upon request (ball, cup, shoe)?	□ follow simple directions (“Shut the door” or “Get your shoes”)?
□ respond correctly to yes/no questions	□respond correctly to who/what/when/where/why questions?

Your child currently communicates using…

□ body language	□ sounds (vowels, grunting).	□ words (shoe, doggy, up).
□ 2 to 4 word sentences	□ sentences longer than 4 words	□ other_____

Behavioral Characteristics

□ cooperative	□ attentive	□ restless
□ poor eye contact	□ willing to try new activities	□ easily distracted/short attention
□ plays alone for reasonable length of time	□ destructive/aggressive	□ separation difficulties
□ withdrawn	□ easily frustrated/impulsive	□ inappropriate behavior
□ stubborn	□ self-abusive behavior	

School History

Name of School:_____ Grade in School:_____

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? _____