Speech Language Learning Connection, LLC

709 Sycamore Avenue
Tinton Falls, NJ 07701

PHONE (732) 450-1111 FAX (732) 450-1144

CASE HISTORY

Child's Full Name _____
first middle last

Birthdate _____
month day year

Address _____
street city state/province zip code

Telephone (home) _____ (work) _____

Referral Source _____

Reason for Referral _____

Child's Physician _____

Other doctors who provide care to this child

Name	Specialty	City

All information given in this questionnaire is considered strictly confidential and will not be provided to other agencies without your written consent.

Family Background

Mother's Name _____ Age _____

Occupation _____ Education Level _____

History of Speech, Language, or Hearing Problems ❑ Yes ❑ No

If "Yes," please explain. _____

_____

Father's Name _____ Age _____

Occupation _____ Education Level _____

History of Speech, Language, or Hearing Problems ❑ Yes ❑ No

If "Yes," please explain. _____

_____

Brothers and Sisters

Name	Age	Speech, Hearing or Medical Problems

Is there a family history (parents, brothers, sisters, aunts, uncles, cousins, grandparents) of any of the following?

	Family Member		Family Member
hearing loss	_____	cleft palate	_____
speech problem	_____	seizure disorder	_____
prematurity	_____	mental illness	_____
blindness	_____	alcoholism	_____
malformation of the head, neck or ears	_____	delayed motor development	_____
educational difficulties	_____	low birth weight	_____
drug use	_____	other	_____

Who is currently living in the home with your child?

____ biological mother ____ biological father ____ adoptive parents

____ unmarried partner ____ brothers ____ sisters

____ other (please specify) _____

Is any language other than English spoken in the home?

❑ Yes Explain: _____ ❑ No

Have there been any of the following major changes in the family during the last year?

____ change of address ____ accident or illness ____ divorce/marriage

____ parent separations ____ death of a family member ____ birth/adoption

Does anyone living in the home smoke? ❑ Yes ❑ No

Statement of the Problem

Describe in your own words the nature of your concerns about your child's development.

_____

_____

When did you first notice this problem? _____

Whom did you first tell about this problem? _____

What was that person's response? _____

What is your child's awareness of/reaction to this problem? _____

_____

How do you and other family members react to this problem? _____

_____

Has your child received any previous treatment for this problem? ❑ Yes ❑ No

If "Yes," where? _____

What information do you hope to gain from this evaluation, and what specific questions or areas do you wish to address? _____

_____

_____

Prenatal and Birth History

Check any of the factors below that apply.

During Pregnancy

___ excessive vomiting	___ hemorrhaging	___ X-ray treatments
___ illnesses (i.e., German Measles)	___ medications	___ Rh incompatibility
___ drug use	___ smoking	___ previous miscarriages
___ excessive weight loss	___ excessive weight gain	___ diabetes
___ premature rupture of membranes	___ need for hospitalization or bed rest	

Mother's general health during pregnancy (illnesses, accidents, medications, etc.).

_____

_____

Length of pregnancy: _____ Length of labor: _____

General condition: _____ Birth weight: _____

Circle type of delivery: head first feet first breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth? ❑ Yes ❑ No

If "Yes," please explain. _____

_____

Child's Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Allergies _____	Asthma _____	Chicken pox _____
Colds _____	Convulsions _____	Croup _____
Dizziness _____	Draining Ear _____	Ear Infections _____
Encephalitis _____	German Measles _____	Headaches _____
High Fever _____	Influenza _____	Mastoiditis _____
Measles _____	Meningitis _____	Mumps _____
Pneumonia _____	Seizures _____	Sinusitis _____
Tinnitus _____	Tonsillitis _____	Other _____

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, adenoidectomy, etc.)?

_____

_____

Describe any major accidents or hospitalizations. _____

_____

Is the child taking any medication? If yes, identify. _____

_____

Have there been any negative reactions to medications? If yes, identify.

_____

_____

Has the child had any injuries to the head? Did your child require any special attention or hospitalization due to a head injury?

_____

_____

Has your child ever used a pacifier or sucked on his/her thumb or fingers?

If yes, how long? _____

Hearing History

Do you suspect your child has a hearing problem? ❑ Yes ❑ No

If "Yes," what behaviors lead you to suspect this? _____

_____

Do you question your child's ability to understand directions or conversations? ❑ Yes ❑ No

If "Yes," what behaviors lead you to suspect this? _____

_____

What do you feel is the cause of the hearing problem? _____

_____

How old was your child when you first suspected a problem with his/her hearing? _____

Has your child's hearing: ___ remained stable ___ fluctuated ___ progressively worsened

Has your child's hearing ever been tested? ❑ Yes ❑ No

Where _____

When _____

By whom _____

Results _____

Recommendations_____

Listening Habits

ability to hear on the telephone _____ ear used _____

radio/stereo/TV _____

ability to hear one-on-one _____

ability to understand in quiet _____

ability to understand in noise _____

ability to locate direction of sounds _____

Has your child ever worn: ___ hearing aid(s) ___ FM system

Which ear? _____

Brand _____

When was the hearing aid first fitted? _____

How old is/are the aid(s)? _____

How long does your child wear hearing aid(s) every day? _____

Do you feel your child benefits from amplification? ❑ Yes ❑ No

Explain. _____

_____

Speech and Language Development

Indicate when your child first demonstrated the following.

Age	Behavior	Age	Behavior
____	cooing, pleasure sounds	____	single words
____	babbling (ba-ba, da-da, etc.)	____	phrases (go bye-bye, more juice)
____	jargon (talking own special language)	____	short sentences

What is the primary method(s) your child uses for letting you know what he/she wants?

____	looking at objects	____	pointing at objects	____	gestures
____	crying	____	vocalizing/grunting	____	physical manipulation
____	single words	____	2-3 word combinations	____	sentences

Which of the following best describes your child's speech?

- ____ easy to understand
- ____ difficult for parents to understand
- ____ difficult for others to understand
- ____ almost never understood by others
- ____ different from other children of the same age

Which of the following statements best describes your child's reaction to his/her speech?

- ____ is easily frustrated when not understood
- ____ does not seem aware of speech/communication problems
- ____ has been teased about her/his speech
- ____ tries to say sounds or words more clearly when asked
- ____ is successful in saying sounds or words more clearly when he/she tries

Is your child aware of his/her communication difficulties? ❑ Yes ❑ No

If "Yes," how does this awareness impact your child's social/emotional status? _____

_____

Does your child have difficulty producing certain sounds? ❑ Yes ❑ No

If "Yes," which ones? _____

Does your child hesitate and/or repeat sounds or words? ❑ Yes ❑ No

Does your child "get stuck" when attempting to say a word? ❑ Yes ❑ No

Do you have concerns about your child's voice? ❑ Yes ❑ No

Which of the following do you think your child understands?

____	his/her own name	____	names of body parts	____	family names
____	names of objects	____	simple directions	____	complex directions
_____	conversational speech				

Motor Development

At approximately what age did your child achieve the following motor milestones?

head support	_____	reach & grasp	_____	sitting alone	_____
crawling	_____	standing alone	_____	walking alone	_____
climbing stairs	_____	finger food	_____	eat with a spoon	_____
potty trained	_____	undressed self	_____		

Is your child overly awkward or clumsy? ❑ Yes ❑ No

Does your child display a hand preference? ❑ Yes ❑ No

If "Yes," which hand does your child prefer to use? _____

Has your child had any feeding difficulties? Check each item that applies.

_____ sucking or nursing
_____ excessive length of time to drink bottle
_____ difficulty chewing or swallowing meats
_____ regurgitation of liquids or solids through the nose
_____ reflux/vomiting
_____ allergies (formula, food)
_____ choking and/or gagging

Does your child choke or cough while eating or drinking? ❑ Yes ❑ No

If "Yes," on what foods/drinks? _____

Is your child a picky eater? ❑ Yes ❑ No

If "Yes," what foods does he/she prefer? _____

Describe any feeding problems your baby experienced during the first three months of life. _____

_____

Does your child drool more than other children his/her age? ❑ Yes ❑ No

Did your child have difficulty gaining weight as an infant? ❑ Yes ❑ No

Explain: _____

Behaviors

Which of the following describes the type of play your child likes to engage in the most often?

___ putting toys in mouth
___ banging toys together
___ throwing toys
___ shaking toys
___ pushing/pulling toys
___ appropriate use of objects
___ uses one object for another
___ acting out familiar routines
___ role-playing
___ make-believe play
___ games with rules
___ rough-and-tumble play
___ looking at books

What is the average length of time your child can stay playing at one activity? _____

Which activities seem to hold your child's attention for the longest period of time? _____

_____

Which activities seem to hold your child's attention for the shortest period of time? _____

_____

Is your child's play easily distracted by any of the following?

____ visual stimuli (i.e., other toys or objects)
____ auditory stimuli (i.e., voices, sounds outside, the TV)
____ nearby activities
____ other people in the room

Whom does your child prefer to play with? (Please circle)

mother father brother/sister self other child other adult

List some of your child's favorite toys, activities, TV programs, and videos. _____

_____

_____

Social/Emotional Development

Check behaviors that you feel best describe your child. Check each item that applies.

____ overly active
____ overly quiet
____ excessive tantrums
____ destructive
____ very shy
____ perfectionistic
____ friendly, outgoing
____ imaginative and creative
____ plays well with other children
____ prefers older children
____ prefers younger children
____ defiant
____ easily controlled/passive
____ nervous
____ dependent upon routines
____ difficulty separating from parent
____ thumb sucking
____ drooling
____ teeth grinding
____ mouth breather
____ toileting issues
____ interrupted/unusual eating habits
____ interrupted/unusual sleeping habits

Describe any discipline problems you have with your child. _____

_____

Has your child been seen by a psychologist, psychiatrist or social worker for behavior or emotional problems?

_____

Was a diagnosis given? _____

Was medication recommended? _____

Educational History

Educational Setting	Location/School	Teacher(s)
Child Care Facility		
Public/Private School Grade _____		
Birth to 3 Program		

How often does your child attend classes?

____ daily ____ 4 times per week ____ 3 times per week

____ 2 times per week ____ ½ days ____ full day

How many children are in your child's class? _____

What type of classroom is your child in? (i.e., traditional, open classroom, transdisciplinary, etc.)

_____

Does your child exhibit any learning style preferences? visual auditory both

Have teachers expressed any concerns about your child's learning behavior? ❑ Yes ❑ No

If so, please describe. _____

_____

Has your child ever been evaluated by:	**Date**	**Location**
_____ speech pathologist	_____	_____
_____ audiologist	_____	_____
_____ vision specialist	_____	_____
_____ neurologist	_____	_____
_____ Child Study Team	_____	_____
_____ other	_____	_____

Is your child classified by the school district to receive special education and/or related services? ❑ Yes ❑ No

If yes, please explain: _____

Date of Classification _____ Type of Classification _____

Date of Last Re-evaluation _____

Type of Services (self-contained class, resource room, in-class support)

_____

Name of Case Manager _____ Phone # _____

Has your child ever been evaluated for or attended therapy for:

___ speech problems ___ vision problems ___ feeding problems

___ hearing problems ___ physical motor problems ___ learning difficulties

___ other _____

Please give locations, dates, and results. _____

_____

Please provide any additional information you feel might be helpful in evaluating your child.

____

____

____

Please list names and addresses of any person or agency you would like to receive a copy of the evaluation report or subsequent treatment reports.

Name ____

Agency ____

Address ____

City, State, Zip ____

Name ____

Agency ____

Address ____

City, State, Zip ____

Name ____

Agency ____

Address ____

City, State, Zip ____

Thank you for your help. Your insights will enable us to do our best for you!

____ ________________________________

Signature of person completing this form Relationship to client

____ ________________________________

SS# of person responsible for payment Name of insurance company

____

Date

- -

Please sign the following release, allowing us to request copies of medical records, school records, Child Study Team evaluation reports, and/or copies of IEPs.

I, ____, hereby give permission to SLLC to request copies

of records and/or reports for my child, ____.

Date: ______________________ ____

Signature