Mary Washington
PEDIATRIC THERAPY
a department of Mary Washington Hospital

200 Executive Center Parkway, Suite 106
Fredericksburg, VA 22401
Phone: 540.446.2654
mwhc.com

Speech and Language Case History

Today's Date:________________

Patient Name:____ Date of Birth: ______/ ______ / ______

Person completing form: _____________________________ Relationship to patient: ________________________

Who is accompanying the child to the evaluation? ____

Current Concerns
Please check the reason(s) for evaluation

- ❑ Speech production
- ❑ Receptive language
- ❑ Expressive language
- ❑ Stuttering
- ❑ Voice concerns
- ❑ Difficulty with transitions
- ❑ Difficulty with following directions
- ❑ Pragmatic language
- ❑ Difficult to understand
- ❑ Difficulty with attending to tasks
- ❑ Difficulty communicating wants/needs
- ❑ Other:

Describe your current concerns *(Please fill out this form as completely as possible).*

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When did you first notice your child's difficulty?

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Describe any problems that appear to a result of your child's difficulty?

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Is there a language(s) other than English spoken in the home? ❑ yes ❑ no

If yes, which one(s) ________________________________ Who speaks the language?________________________

Does the child speak the language? ❑ yes ❑ no

Does the child understand the language? ❑ yes ❑ no

Which language does the child prefer to speak at home? ____

Did your child receive a Speech/Language Evaluation within the last 6 months? ❑ yes ❑ no

If yes, where and what were the results?

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Has your child received any other evaluation or therapy (physical therapy, counseling, vision, etc.)? ❑ yes ❑ no

If yes, please describe:

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Has he/she ever had a hearing evaluation/screening? ❑ yes ❑ no

If yes, where and when? What were you told?

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Birth History

Was there anything unusual about the pregnancy or birth? ❑ yes ❑ no

If yes, please describe:

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List any medications taken during pregnancy.

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Was the mother sick during the pregnancy? ❑ yes ❑ no

If yes, please describe:

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

Length of pregnancy in weeks: ______________________ **Birth weight** ________________

Was the child able to go home with the mother? ❑ yes ❑ no

If no, please describe:

Medical History

Are immunizations up to date? ❑ yes ❑ no

Has your child had any of the following?

- ❑ Seizures
- ❑ Head injury
- ❑ Allergies
- ❑ Sinusitis
- ❑ Flu
- ❑ Breathing difficulties
- ❑ RSV
- ❑ High Fevers
- ❑ Colds
- ❑ Sleeping difficulties
- ❑ Snoring
- ❑ Drooling
- ❑ Thumb/finger sucking habit
- ❑ Tongue/lip tie
- ❑ Ear infections
- ❑ PE ear tubes
- ❑ Tonsillectomy
- ❑ Adenoidectomy
- ❑ GI issues/constipation issues
- ❑ Vision problems
- ❑ Hearing issues
- ❑ Other

List any allergies *(medicine, food, pets, seasonal)*

List all medications/supplements and dosages that the child currently takes, including over the counter (i.e vitamins etc.)

Any feeding issues as an infant or toddler (latching on, poor weight gain etc)?

Is your child a picky eater, or have any feeding difficulties (pocketing food, choking/gagging)?

Is your child currently (or recently) under a physician's care? ❑ yes ❑ no

If yes, why?

Developmental Milestones

What approximate age did your child achieve the following developmental milestones?

Crawl?
Age achieved in months: ____________________________

Sit up?
Age achieved in months: ____________________________

Walked?
Age achieved in months: ____________________________

Fed Self?
Age achieved in months: ____________________________

Dress self?
Age achieved in months: ____________________________

Toileted?
Age achieved in months: ____________________________

Speech and Language Milestones

What approximate age did your child achieve the following speech and language milestones?

Babble/Coo?
Age achieved in months: ____________________________

Respond to their name?
Age achieved in months: ____________________________

Imitate sounds/use jargon?
Age achieved in months: ____________________________

Say first words?
Age achieved in months: ____________________________

Put two words together?
Age achieved in months: ____________________________

Use short sentences?
Age achieved in months: ____________________________

Does your child…

Currently put toys/objects in his/her mouth? ❑ yes ❑ no ❑ N/A

Brush his/her teeth and/or allow brushing? ❑ yes ❑ no ❑ N/A

Does your child currently…..(check all that apply)

- ❑ 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/where/when/why questions?

Your child currently communicates using…

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

Behavioral Characteristics (check all that apply):

- ❑ Cooperative
- ❑ Willing to try new activities
- ❑ Plays alone for reasonable length of time
- ❑ Separation difficulties
- ❑ Easily frustrated/impulsive
- ❑ Stubborn
- ❑ Restless
- ❑ Attentive
- ❑ Easily distracted/short attention
- ❑ Destructive/aggressive
- ❑ Withdrawn
- ❑ Inappropriate behavior
- ❑ Self-abusive behavior
- ❑ Lack of appropriate eye contact

Family Information

Who does the child live with (i.e. parents, siblings, grandparents)?

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____

____

Is there a family history of speech, language, or hearing difficulties or other diagnoses?

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Who and where does the child spend most of their time (i.e. parents, family, school, home)?

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What are your child's favorite items (i.e. toys, characters, food items, places to visit)?

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Educational History

Does your child attend school? ❑ yes ❑ no

If Yes, name of school:______________________________ Grade:__________

Does your child have an IEP from the public schools? ❑ yes ❑ no

Has your child experienced any difficulties in school? ❑ yes ❑ no

If Yes, please explain:

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Additional information:

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