

**COMMUNICATION FOUNDATIONS  
SPEECH AND LANGUAGE CASE HISTORY FORM**

**Please complete this form PRIOR to coming to your speech and language evaluation in order for us to provide a complete and comprehensive evaluation for your child.**

**Today's Date:** \_\_\_\_\_

**Patient's name:** \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Mother's name: \_\_\_\_\_ Age: \_\_\_\_\_

Father's name: \_\_\_\_\_ Age: \_\_\_\_\_

Parents' Marital Status: \_\_\_\_\_

**Pediatrician or Primary Care Provider**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Primary Language in the Home:** \_\_\_\_\_

**Current Concern**

Primary concern is:

- Speech
- Language (not talking or understanding appropriately for age)
- Voice
- Fluency (Stuttering)
- Feeding/Swallowing

Please describe the concern that prompted you for this evaluation:

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**Diagnoses or Syndromes:**

Please check all that apply to your child.

- |   |   |
|---|---|
| <input type="checkbox"/> Apraxia  | <input type="checkbox"/> Obsessive-Compulsive Disorder (OCD)    |
| <input type="checkbox"/> Attention Deficit-Hyperactivity Disorder (ADHD or ADD) | <input type="checkbox"/> Pervasive Developmental Disorder (PDD) |
| <input type="checkbox"/> Asperger's Syndrome                                    | <input type="checkbox"/> Pierre Robin Sequence                  |
| <input type="checkbox"/> Autism   | <input type="checkbox"/> Sensory Integration Disorder           |
| <input type="checkbox"/> Central Auditory Processing Disorder                   | <input type="checkbox"/> Seizure Disorder                       |
| <input type="checkbox"/> Cerebral Palsy   | <input type="checkbox"/> Stickler's Syndrome                    |
| <input type="checkbox"/> CHARGE Syndrome  | <input type="checkbox"/> Velocardiofacial Syndrome              |
| <input type="checkbox"/> Down Syndrome  | <input type="checkbox"/> Other _____                            |
| <input type="checkbox"/> Hearing Impairment                                     |   |
| <input type="checkbox"/> Neurological Disorder                                  |   |

**Surgeries and Hospital Admissions:**

Please list and give the approximate date:

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Child's current medications:

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**Hearing Status**

Hearing has been tested? Yes \_\_\_\_\_ No \_\_\_\_\_

Date and result of hearing test: \_\_\_\_\_

I would like to schedule a future appointment with the audiologist to have my child's hearing tested. Yes \_\_\_\_\_ No \_\_\_\_\_

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**Medical History**

Please check all that apply to your child.

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Visual problems   |
| <input type="checkbox"/> Birth defect             | <input type="checkbox"/> Meningitis  |
| <input type="checkbox"/> Oxygen required at birth | <input type="checkbox"/> Prematurity   |
| <input type="checkbox"/> Cleft lip                | <input type="checkbox"/> Developmental delay   |
| <input type="checkbox"/> Cleft palate             | <input type="checkbox"/> Learning disability   |
| <input type="checkbox"/> Prenatal problems        | <input type="checkbox"/> Poor motor coordination   |
| <input type="checkbox"/> Early feeding problems   | <input type="checkbox"/> Hyperactivity   |
| <input type="checkbox"/> Frequent ear infections  | <input type="checkbox"/> Severe headaches  |
| <input type="checkbox"/> Hearing loss             | <input type="checkbox"/> Brain damage  |
| <input type="checkbox"/> Heart defect             | <input type="checkbox"/> Head injury   |
| <input type="checkbox"/> Mouth breathing          | <input type="checkbox"/> Feeding or swallowing problems                                      |
| <input type="checkbox"/> Pneumonia                | <input type="checkbox"/> Seizures/convulsions  |
| <input type="checkbox"/> Sleep apnea              | <input type="checkbox"/> Nasal regurgitation (Passes liquids through the nose when drinking) |
| <input type="checkbox"/> Low birth weight         | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Tracheostomy             |  |
| <input type="checkbox"/> Tuberculosis             |  |

**Development:**

Please indicate the ages at which your child began the following:

Sitting alone	Cooing
Crawling	Babbling
Standing alone	Using single words
Walking alone	Using 2 or 3 word utterances
Using toilet	Using phrases
Dressing self	Using sentences

**Treatment History**

Please check all that apply to your child. Give facility or provider and dates.

- Speech/Language Therapy \_\_\_\_\_
- Occupational Therapy \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- ABA \_\_\_\_\_
- Tutoring: Reading or Math \_\_\_\_\_
- Special Needs Classroom \_\_\_\_\_
- Other: \_\_\_\_\_

*Please bring current evaluations or IEPs if you feel this would help us to better understand your child's skills and needs.*

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**School History**

Please list preschools and schools your child has attended:

**School**

**Dates**

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Current Grade: \_\_\_\_\_

**Additional Information:**

Please give us any additional information that you feel we need for this evaluation.

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***Thank you.***

*We look forward to working with you and your child.*