

Nashville Child and Family Wellness Center
Child Speech Language Case History Form

Provider Child is scheduled to see: _____

Child's Name: _____ Today's Date: _____

Name of Person Completing this: _____

Relationship to child: _____

I. Presenting Concerns

Child's Diagnosis: _____

Why are you bringing your child for an evaluation? What are your concerns?

When did these concerns first occur?

Do any other family members have similar issues?

What would you like for your child to accomplish during treatment? _____

II. Additional Medical History

Does your child have any ear infections? No Yes If yes, please explain:

Does your child Have tubes in ears? No Yes If yes, please explain:

Has your child's hearing ever been tested? No Yes If yes, please provide:

Date of Assessment: _____

Who completed the assessment? _____

What were the results? _____

Has your child's vision ever been tested? No Yes If yes, please provide:

Date of Assessment: _____

Who completed the assessment? _____

What were the results? _____

III. Early Intervention/Education

Is your child in an early intervention program? No Yes If yes, please describe:

School/Program Name: _____ Current Grade: _____
Days attends (circle) M T W R F Name of teacher: _____
TEIS/TIPS Service Coordinator(s): _____

Has your child exhibited behavior problems at school? No Yes
If yes, please explain: _____

Are there concerns at school? No Yes
If yes, please explain: _____

IV. Social and Emotional Functioning

Check all that apply to your child:

- | | |
|---|---|
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Bang head |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Rock body excessively |
| <input type="checkbox"/> Difficulty transitioning between activities | <input type="checkbox"/> Bite self |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Stare at objects |
| <input type="checkbox"/> Nervous, restless, or fidgety | <input type="checkbox"/> Have sleeping problems |
| <input type="checkbox"/> Have unusual fears | <input type="checkbox"/> Dislike swinging or other movement |
| <input type="checkbox"/> Destructive or rough with toys/activities | <input type="checkbox"/> Likes excessive swinging or movement |
| <input type="checkbox"/> Have temper tantrums | <input type="checkbox"/> Oversensitive to sounds |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Oversensitive to lights |
| <input type="checkbox"/> Cry easily | <input type="checkbox"/> Oversensitive to smells |
| <input type="checkbox"/> Become upset with certain textures on the skin or in the mouth | <input type="checkbox"/> Becomes frustrated easily |
| | <input type="checkbox"/> Unable to calm self when upset |

Are there certain activities that your child avoids or has difficulty with? No Yes
If yes, please explain: _____

V. Gross Motor Milestones

Please comment on stages child has reached and at what age:

Raising head while on tummy _____	Walking _____
Rolling _____	Throwing a ball _____
Sitting alone _____	Stair climbing _____
Belly or 4-point crawling _____	Jumping _____
Standing alone _____	Tricycle use _____

VI. Fine Motor/Visual Motor Skill

Does your child avoid manipulation of small objects? No Yes
If yes, please explain: _____

Does your child avoid activities that involve the use of both hands, such as stringing beads or buttoning?

No Yes If yes, please explain: _____

Does your child avoid activities involving the use of "tools" such as utensils, crayons, pencils, markers, or scissors?

No Yes If yes, please explain: _____

Do you feel that your child has not yet established a definite hand preference when using a spoon, crayon, maker, pencil, etc.?

No Yes If yes, please explain: _____

Does your child enjoy visual motor activities like building with blocks or simple puzzles?

No Yes If yes, please explain: _____

VII. Cognitive Development and Communication

Do you feel your child is able to understand and follow directions for his/her age level?

Yes No If no, please explain: _____

Do you feel your child is able to remember important details?

Yes No If no, please explain: _____

Do you feel your child is able to express his/her wants or needs?

Yes No If no, please explain: _____

Communication Milestones

Please comment on stages child has reached and what age:

Babbling: _____ Single words: _____

Combining words: _____ Sentences: _____

VIII. Feeding History

Were/Are there any breast/bottle feeding issues or problems?

No Yes If yes, please explain: _____

Did you child transition easily to sold foods or from bottle to cup drinking?

No Yes If no, please explain: _____

Are there specific foods (or food textures) your child avoids or has difficulty eating?

No Yes If yes, please explain: _____

Is your child able to feed him/herself with or without utensils? No Yes

If no, please explain: _____

IX. Previous Therapy

Has your child received any treatment from an Occupational, Speech or Physical therapist before?

No Yes If yes, check all that apply and note type of therapy and dates:

Occupational Therapy _____

Speech Therapy _____

Physical Therapy _____

Has your child received a previous evaluation in any of these areas? No Yes

If yes, when and what were the findings? _____

**If the evaluation was completed within the last year, please bring a copy of it to your scheduled evaluation.

X. Comments

Please list any additional concerns or comments in the space below.

Thank you for your time filling out this questionnaire, so that we can better understand your child and your concerns.