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. <u>Presenting Concerns</u>
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. <u>Additional Medical History</u>

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. <u>Early Intervention/Education</u>

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

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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:

- ☐ Hyperactive
- ☐ Low energy
- ☐ Difficulty transitioning between activities
- ☐ Short attention span
- ☐ Nervous, restless, or fidgety
- ☐ Have unusual fears
- ☐ Destructive or rough with toys/activities
- ☐ Have temper tantrums
- ☐ Shy
- ☐ Cry easily
- ☐ Become upset with certain textures on the skin or in the mouth
- ☐ Bang head
- ☐ Rock body excessively
- ☐ Bite self
- ☐ Stare at objects
- ☐ Have sleeping problems
- ☐ Dislike swinging or other movement
- ☐ Likes excessive swinging or movement
- ☐ Oversensitive to sounds
- ☐ Oversensitive to lights
- ☐ Oversensitive to smells
- ☐ Becomes frustrated easily
- ☐ 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 _____________
Rolling _________________________________
Sitting alone _____________________________
Belly or 4-point crawling _________________
Standing alone ___________________________
Walking _________________________________
Throwing a ball __________________________
Stair climbing ___________________________
Jumping _________________________________
Tricycle use _____________________________

VI. Fine Motor/Visual Motor Skill

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

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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: ____
____

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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.

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