Department of Communication Disorders
Edgar R. Garrett Speech and Hearing Center
New Mexico State University
P.O. Box 30001 MSC 3SPE
Las Cruces, NM 88003-8001
Phone: (575) 646-3906
Fax: (575) 646-3140

CASE HISTORY FORM – CHILD

GENERAL INFORMATION

Child's Name: ______________________________ DOB: ______________ ☐Male ☐Female

Mailing Address, City, State, Zip: ____

Phone #: ______________________ Email Address: _______________________________

Form Completed by: ____

How did you hear about us?
☐Word of Mouth ☐Advertisement ☐NMSU Faculty ☐Other: __________________

PEDIATRICIAN & BENEFIT INFORMATION

Primary Physician: __________________________________ Phone #: _______________________

Is your child enrolled in Medicare Part B? ☐Yes ☐No

Does your child receive Social Security Disability Insurance (SSDI)? ☐Yes ☐No

FAMILY INFORMATION

Parent/Guardian: _______________________________ Occupation: ____________________

Address, City, State, Zip: ____

Phone #: ________________________________

Parent/Guardian: _______________________________ Occupation: ____________________

Address, City, State, Zip: ____

Phone #: ________________________________

Names of Others Living with Child	Relationship to Child	Age	Gender

Family History of speech, language, hearing or learning difficulties? ☐Yes ☐No

If yes, please explain: ____

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Languages Spoken in the Home: ____

Languages that Child Speaks: ____

Child's Primary Language: ____

Is the child adopted? ☐Yes ☐No
If yes, at what age? _____________ Country of Origin: ___________________________________

With whom does the child spend most of his/her time? ___________________________________

STATEMENT OF PROBLEM

Describe the concerns you have about your child's communication skills: ___________________

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What do you think may have caused the difficulties? ____________________________________

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When did you first notice the difficulties? ____

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Are there any skills your child learned previously but no longer uses? ______________________

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Is the child aware of his/her difficulties? How does he/she feel about it? ___________________

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Has your child's hearing been tested? ☐Yes ☐No

If yes, where and who completed the testing? __________________________________

Results of Test: ☐Within Normal Limits ☐Further Testing Necessary ☐Hearing Loss

Does your child have: ☐Hearing Aids ☐Cochlear Implants ☐Tubes in Ear(s)

Has your child's vision been tested? ☐Yes ☐No

If yes, where and who completed the testing? ____________________________________

Results of Test: ☐Vision Within Normal Limits ☐Further Testing Necessary

Has your child ever received speech therapy? ☐Yes ☐No

If yes, when, where and for how long? ____

****If you answered "yes" to these questions, please bring a copy of the testing results.*

BIRTH AND MEDICAL HISTORY

Mother's health during pregnancy can be described as:
☐Excellent ☐Good ☐Fair ☐Poor

If described as "fair" or "poor", please explain: ____

____

Was there anything unusual or problematic during your pregnancy or birth? ☐Yes ☐No

If yes, please describe: ____

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Medications during pregnancy: ____

Drug/Alcohol/Tobacco Use during pregnancy: ☐Yes ☐No

# of weeks gestation when child was born: ________

Any illnesses during pregnancy: ☐Yes ☐No
If yes, please explain: ____

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Child's Birth Weight: ___________ Height: ___________

Does your child have any diagnosed medical conditions? ☐Yes ☐No
If yes, please explain: ____

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My child is currently on medications: ☐Yes ☐No
If yes, which ones and why: ____

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Has your child had any of the following?

□Asthma	□ Chicken Pox	□ Cold	□ Croup	□ Dizziness
□Mumps	□ Measles	□ High fever	□ Tonsillitis	□ Draining ears
□ Headaches	□ Pneumonia	□ Meningitis	□ Seizures	□ Ear infections
□Tinnitus	□ Encephalitis	□ Mastoiditis	□ Sinusitis	□ German Measles

Other: ____

Has your child been involved in any major accidents or been hospitalized? □Yes □No
If yes, when/why: ____

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EATING AND FEEDING

Does your child eat a variety of foods? □Yes □No
If no, please explain: ____

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____

Allergies to foods? □Yes □No
If yes, which foods: ____

____

Had your child had any difficulty with feeding? □Yes □No
If yes, please answer below:
My child has issues with:
□sucking □chewing □swallowing □drooling □latching

My child: (check all that apply)
□eats finger foods □uses a fork/spoon □uses an open cup □uses a Sippy cup

□eats with assistance □eats without assistance

DEVELOPMENTAL HISTORY

Motor Skills/Self Help

Provide the approximate age at which your child began doing the following and describe how this compares to other child his/her age.

Activity	Age	Earlier Than Peers	Same As Peers	After Peers
Crawl				
Sit unsupported				
Stand unsupported				
Walk				
Feed self				
Dress self				
Use Toilet				

My child has difficulty:
☐Walking ☐Running ☐Jumping
☐Participating in Activities That Require Large Muscle Movements
☐Grasping ☐Writing/Coloring ☐Picking Up Small Items
☐Participating in Activities That Require Small Muscle Movements

Speech & Language

Activity	Age	Earlier Than Peers	Same As Peers	After Peers
Babble *(e.g. ba-ba-ba, ma-ma-ma)*				
Use single words *(e.g. no, mom, doggie)*				
Combine two words *(e.g. Me go. Daddy shoe.)*				
Name simple objects *(e.g. apple, dog, car)*				
Use simple questions (e.g.Where's doggie?)				
Use full sentences *(e.g. I want a cookie.)*				
Engage in conversation				
Follow simple directions *(e.g. Show me your shoe.)*				
Follow 2-part directions *(e.g. Find the ball, and put it in the box.)*				

Activity	Always	Sometimes	Never
I understand what my child is saying when he/she is speaking.			
Our extended family and friends understand what my child is saying when he/she is speaking.			
My child sometimes substitutes speech sounds.			
When my child makes a sound error when speaking, it's always the same sound substituted.			
My child engages in play with other children			
My child engages in imaginative play.			
My child responds to his/her name			
My child repeats words, sounds and/or phrases			
My child has a hoarse or raspy voice.			
My child has difficulty writing and reading			
My child speaks in full sentences.			

My child generally communicates by:
□Gestures □Using single words □Using short phrases (2-3 words)
□Sentences □Sign □Uses an AAC device

How often do you, family & friends understand your child when he/she speaks?

	25%	50%	75%	90-100%
Parents/ siblings/household				
Extended family and friends				

Are there situations where your child exhibits more difficulty communicating? □Yes □No
If yes, please explain: ____

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Educational History

Name of School: ___________________________________ Grade: ___________

Teacher: ______________________________________

Describe how you feel your child is doing in school or in preparation for school. Check those that apply:
□no difficulty □minimal difficulty □moderate difficulty □severe difficulty

Does your child receive special services? □Yes □No
If yes, check those that apply:
□Early Intervention □Speech Therapy □Physical Therapy □Occupational Therapy
□Behavioral Therapy □SPED services □Other: ____________________________________

How long has your child been receiving these services? ________________
Does your child have an IEP/IFSP? □Yes □No
If yes, please provide a copy of your IEP/IFSP.

Is there any additional information you might want to provide that will assist with the evaluation or remediation of your child?

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Name of person completing this document: ____

___________________________________ ____________________________________
(Printed Name) (Signature)

Relationship to Child: ____________________________ Date: _________________________