

**CHARLOTTE SPEECH AND HEARING CENTER  
CHILD'S CASE HISTORY**

Child's Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Date Completed \_\_\_\_\_

Please answer all questions. Explain as needed. Thank you for your time and information.

**1. Statement of Problem:**

**Yes / No**

- \_\_\_\_ \_\_\_\_ 1. Does child have trouble speaking clearly? List difficult letters/sounds \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ 2. Does child seem to have trouble understanding what you say?
- \_\_\_\_ \_\_\_\_ 3. Does child seem to stutter?
- \_\_\_\_ \_\_\_\_ 4. Does child seem to use less words and sentences than other children his/her age do?
- \_\_\_\_ \_\_\_\_ 5. Has the problem gotten worse in the last 6 months?
- \_\_\_\_ \_\_\_\_ 6. Has child's teacher/doctor/others commented on child's speech or hearing?
- \_\_\_\_ \_\_\_\_ 7. Have other family members had similar problem?
- \_\_\_\_ \_\_\_\_ 8. Is child aware of problem? How can you tell? \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ 9. Have you tried any ways to help child at home? \_\_\_\_\_

**2. Birth History:**

**Yes / No**

- \_\_\_\_ \_\_\_\_ 1. Did you have an unusual pregnancy, labor or delivery? \_\_\_\_\_  
List any medication or other substances used during pregnancy: \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ 2. Did newborn have medical complications following birth? \_\_\_\_\_  
If yes, Explain: \_\_\_\_\_

**3. Development History:**

**Yes / No**

- \_\_\_\_ \_\_\_\_ 1. Did child have difficulty sucking, swallowing, feeding? (circle problem areas)
- \_\_\_\_ \_\_\_\_ 2. Did child have preference for soft foods? \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ 3. Did early motor development (crawling, walking) seem delayed?
- \_\_\_\_ \_\_\_\_ 4. Is child in diapers?
- \_\_\_\_ \_\_\_\_ 5. Did early speech development (use of single words, sentences) seem delayed?
- \_\_\_\_ \_\_\_\_ 6. Does child have trouble playing and interacting with other children his/her age?
- \_\_\_\_ \_\_\_\_ 7. Does child appear to have any unusual behaviors? \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ 8. Does child have any unusual reactions to touch, sounds, smells, textures, etc.?

**4. Medical History:**

**Yes / No**

- \_\_\_\_ \_\_\_\_ 1. Has child had difficulty with (circle problem areas):
- ear infections / hearing allergies      tonsils and adendoids      frequent colds      drooling**
- mount breathing      asthma fevers      seizures vision      physical disabilities**
- other significant medical information related to speech? \_\_\_\_\_**
- \_\_\_\_\_

\_\_\_ \_\_\_ 2. Is your child currently taking medication? \_\_\_\_\_

\_\_\_ \_\_\_ 3. Is child missing any of his/her immunization shots? \_\_\_\_\_

**5. Family / Educational History:**

**Yes / No**

\_\_\_ \_\_\_ 1. Does child live with both parents?

\_\_\_ \_\_\_ 2. Does child have brothers and sisters? Ages \_\_\_\_\_

\_\_\_ \_\_\_ 3. Are any foreign languages spoken or is sign language used in the home?

\_\_\_ \_\_\_ 4. Does child attend daycare/preschool? Where? \_\_\_\_\_

\_\_\_ \_\_\_ 5. Do you have any concerns about child's attention span? \_\_\_\_\_

\_\_\_ \_\_\_ 6. Do you have any concerns about child behavior?

\_\_\_ \_\_\_ 7. Does child have trouble adapting to change?

\_\_\_ \_\_\_ 8. Have any of these changes occurred in the past year?

Moving birth death separation divorce other: \_\_\_\_\_

\_\_\_ \_\_\_ 9. Has child been tested at this or another agency before?

Where? \_\_\_\_\_ When? \_\_\_\_\_

What for? \_\_\_\_\_

**Please circle words that describe your child the majority of the time:**

**Mild-mannered   friendly   talkative   tries new things   perfectionist   aggressive   shy**  
**hard to manage   temper tantrums   give up easily   separating from parent difficult**

Please list the kind(s) of discipline that works for your child: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

