

Austin Voice Institute

Dara Whitehead Allen, M.S., CCC-SLP

Case History

DEMOGRAPHIC INFORMATION

Child's Name: _____ Date: _____

Date of Birth: _____ Sex: _____

Multiple Birth TWIN/TRIPLET/ _____ Adopted YES/NO

Address: _____

No./Street City/State Zip Code _____

Home Phone #: _____

Person completing this form _____

Relationship to patient _____

Who referred you to Ms. Allen? _____

Guardian1 Name: _____ Age _____

Work/ Mobile #: _____ E-Mail _____

Education _____

Employer _____

Job _____

Guardian2 Name: _____ Age _____

Work/ Mobile #: _____ E-Mail _____

Education _____

Employer _____

Job _____

Who has legal custody of the patient? _____

Do you have court documents that state the legal custody arrangements of this patient? YES NO NOT APPLICABLE

Siblings (include names and ages):

What languages are spoken in the home? What languages are spoken at school?

What languages does the child speak? _____

Describe the concerns regarding your child's speech-language skills:

Describe the major strengths or assets you observe in your child:

Does the child have any allergies (Please list)

CONCERNS (PLEASE CHECK ALL THAT APPLY TO YOUR CHILD)

- HEARING (has a hearing loss, seems to not hear information, needs repetition)
- SPEECH ARTICULATION (difficult to understand or poor sound production)
- EXPRESSIVE LANGUAGE SKILLS (unable to relay thoughts clearly)
- RECEPTIVE LANGUAGE SKILLS (difficulty following directions, concepts)
- ORAL MOTOR FUNCTIONING (drooling, tongue thrust, muscle strength)
- SWALLOWING/FEEDING (cough/chokes with food, decreased chewing)
- OTHER Please Explain:

Is there any family history of speech and language difficulties? YES NO
Who? Please describe _____

How does your child usually communicate (gestures, single words, phrases, sentences, other)?

What does he/she do when he/she needs help? _____

How does your child let you know that he/she wants an object that is out or reach?

How does your child attract your attention if you are busy doing something (e.g., talking on the telephone, cooking dinner)? _____

How does your child greet someone when that person is arriving or leaving the room? _____

Does your child like to play social games with you (e.g., “peek-a-boo” or “I’m gonna get you”)? Which ones? How does he/she ask to play the games or keep the game going? _____

How does he/she get you to look at something that he/she wants you to notice? _____

How does your child let you know that he/she is upset or frustrated? _____

Is your child able to understand (check as many as applicable)

____ gestures ____ words ____ short phrases ____ sentences

Do gestures need to be used for your child to understand words, short phrases or sentences? YES NO

When was your child’s speech language difficulties first noticed? By whom?

Does the child seem to be aware of his/her speech-language challenges? _____

Are there any other speech, language, or hearing problems in your family? _____
If yes please describe. _____

MEDICAL & DEVELOPMENTAL HISTORY

MATERNAL HISTORY

Did the mother take medication during pregnancy? If yes what, why, when and for how long. _____

Did any of the following occur during pregnancy? Explain causes and/or treatment

- Bleeding _____
 - Rh incompatibility of parents _____
 - Measles _____
 - Accidents _____
 - Illness/Infections _____
 - Rashes _____
-

BIRTH HISTORY

How long was the mother's pregnancy? _____

Was labor induced? _____

What medications were given during birth and to whom? _____

How long was labor? _____ Were forceps used? _____

What were the child's apgar scores? _____ What was the birth weight? _____

Explain any significant occurrences during the child's birth(i.e. trauma, cord wrapped around neck, jaundice, heart issues, feeding problems, need for medical attention/oxygen)

MEDICAL HISTORY

Has the child's health been **good, fair** or **poor**? _____

Please check any of the following occurrences:

- | | |
|---|---|
| <input type="checkbox"/> ear infections | <input type="checkbox"/> constipation |
| <input type="checkbox"/> allergic reactions | <input type="checkbox"/> special diet |
| <input type="checkbox"/> tubes in ears | <input type="checkbox"/> takes medicine regularly |
| <input type="checkbox"/> reflux | <input type="checkbox"/> eczema |
| <input type="checkbox"/> rsv/pneumonia | <input type="checkbox"/> seasonal allergies |

SOCIAL AND EDUCATIONAL HISTORY

Does your child have the opportunity to play with other children his/her age? _____

What are his/her favorite toys and activities? _____

School child is currently attending: _____

Grade: _____ Teacher: _____

How is your child doing academically or pre-academically?

How does the child interact with others, both adults and peers (ie. shy, aggressive, uncooperative, etc.)? _____

Has the child received any therapies (speech, occupational therapy, physical therapy) through school or any other setting? Please list all and provide types, dates of when they began and how long these therapies lasted.

Please circle the response that most appropriately describes your child.

Frequently (F) Occasionally (O) Never (N)

Has trouble completing tasks when the radio is on F – O – N

Is distracted/ has trouble functioning if there is a lot of noise F – O – N

Can't work with environmental noise such as loud fan/vacuum F – O – N

Appears to not hear what you say (tunes you out or ignores you) F – O – N

Doesn't respond when name is called F – O – N

Cries or covers ears when hears loud noises F – O – N

Enjoys music and noise and uses it to calm down F – O – N

DEVELOPMENTAL HISTORY

At what age did the child reach the following developmental milestones?

Sit unsupported _____ Crawl _____ Walk _____

Begin saying words _____ Put 2-3 words together _____

Answer questions or relate information verbally? _____

Bowel Control _____ Bladder Control _____

Use toilet _____ Feed self _____ Stand _____ Dress self _____

Approximately how many words are in the child's vocabulary: _____

Compared to siblings or peers, was speech development **fast**, **slow** or **average**?

FEEDING / ORAL-MOTOR HISTORY

Was the child breast-fed? **YES NO** How long? _____

Was the child bottle-fed? **YES NO** How long? _____

Does he/she drink from a cup without assistance, or without losing any liquid from the mouth? **YES NO**

Does he/she feed him/herself? **YES NO** How? _____

If the child has food/texture issues, which texture/temperature is most preferred?

Crunchy _____ Sour _____ Warm _____ Thick liquid _____

Salty _____ Hot _____ Pureed _____

Cold _____ Semi-solid _____ Spicy _____

Chewy _____ Sweet _____ Room temp. _____

Has/does the child currently display any of the following difficulties?

- | | |
|---|--|
| <input type="checkbox"/> choking/gagging | <input type="checkbox"/> poor chewing |
| <input type="checkbox"/> over-stuffing of food into mouth | <input type="checkbox"/> sticks tongue out when eating |
| <input type="checkbox"/> spitting out of food | <input type="checkbox"/> hard time using straw/cup |
| <input type="checkbox"/> drooling | <input type="checkbox"/> food allergies |
| <input type="checkbox"/> special diet | <input type="checkbox"/> dislikes face washing |
| <input type="checkbox"/> spillage of food from mouth | <input type="checkbox"/> hates brushing teeth |
| <input type="checkbox"/> food texture preferences | <input type="checkbox"/> bites/chews non-food items |
| <input type="checkbox"/> swallowing food whole | |

ADDITIONAL NOTES:

Guardian Speech/Language Assessment

After reading each item below, please circle the response that best describes how well the statement relates to your child:

SA= Strongly Agree

A= Agree

U= Undecided or not applicable

D= Disagree

SD= Strongly Disagree

SA A U D SD

1. My child speaks well.

SA A U D SD

2. I worry about my child's speech and/or language skills.

SA A U D SD

3. My child's communicates primarily via pointing, gesturing, or grunting (instead of talking).

SA A U D SD

4. People frequently tell me that my child has a speech problem.

SA A U D SD

5. My child has a difficult time being understood by his/her peers.

SA A U D SD

6. My child has a difficult time being understood by adults other than his family.

SA A U D SD

7. My child's speech is as good as it should be at his/her age.

SA A U D SD

8. I think my child's speech is immature.

SA A U D SD

9. I understand almost everything my child says.

SA A U D SD

10. I worry about other children teasing my child because of his/her speech.

SA A U D SD

11. My child has difficulty following directions at home/school.

SA A U D SD

12. My child is embarrassed or frustrated because of his/her speech.

SA A U D SD

13. My child does not have difficulties communicating.

SA A U D SD

14. Other children seem to talk better than my child.

SA A U D SD

15. My child pronounces most words clearly.

SA A U D SD

16. I think my child needs speech therapy.

SA A U D SD

17. My child often has to repeat things in order to be understood by peers and adults.

SA A U D SD

18. My child has difficulty understanding what others say.

SA A U D SD

19. My child has difficulty finding the words he wants to say.

SA A U D SD

20. My child frequently asks "what?"

SA A U D SD

21. My child frequently gets stuck on words.

SA A U D SD

22. My child frequently repeats parts of words or entire words.

SA A U D SD

23. I think my child has difficulty hearing what others say.

SA A U D SD

24. My child often asks me to repeat things that I ask or say.

SA A U D SD

25. My child is hesitant about interacting with his/her peers.

SA A U D SD

26. My child interacts well with peers.

SA A U D SD

27. I am concerned about my child's behavior.

SA A U D SD

Comments: