UNIVERSITY OF FLORIDA SPEECH AND HEARING CLINIC
CHILD SPEECH/LANGUAGE PATHOLOGY CASE HISTORY FORM

Please return completed form to:

Univ. of Florida Speech and Hearing Clinic
435 Dauer Hall
University of Florida
Gainesville, FL 32611
(352) 392-2041

ATTN: Betsy P. Vinson, M.M.Sc., CCC/SLP
Director of Clinical Education

IDENTIFYING INFORMATION

Child's Legal Name: ____________________________ Nickname: _________________

Date of Birth: ____________ Age: _______ Date History Form Completed: __________

Parents'/Legal Guardians' Name(s): ____

Address: ____
Street City/State Zip Code

Mailing Address (if different): ____

Person Completing This Form: ____
Name Relationship

Mother's Employer: _____________________________ Job Title: _________________

Mother's Daytime Phone #: __________________ Evening Phone #: ________________

Father's Employer: ______________________________ Job Title: _________________

Father's Daytime Phone #: ___________________ Evening Phone #: ________________

Child's Soc. Sec. #: _________________________

Do you have Medicaid? Yes _____ No _____

If yes, please provide your policy/card #: _____________________(8 digits)

Name of family doctor or referring physician: __________________________________

Telephone # of family doctor/ referring physician: _______________________________

Name of Insured Individual: ____

Name of Person Responsible for Payment: ______________________________________

Address/Phone (if different from above): _______________________________________

REFERRAL INFORMATION

Who referred the child to this clinic?

☐ Pediatrician	☐ Relative	☐ Self/Parent
☐ Teacher	☐ Friend	☐ Other ________________

Would you like the referring individual to receive a copy of the report? ☐ Yes ☐ No

Address: ____
Street City/State Zip Code

Are there others who should receive a copy of the report? ☐Yes ☐ No If yes, who?

Name: ____

Address: ____
Street City/State Zip Code

Name: ____

Address: ____
Street City/State Zip Code

What is the reason for referral (check all that apply)?

☐ Diagnosis	☐ School Placement
☐ Treatment	☐ Other _____________________________________

PRESENT COMMUNICATION STATUS

Please describe your child's speech: ____
____

Have diagnostic or therapeutic services related to the speech problem previously been received?
☐ Yes ☐ No If yes, by whom and when? _____________________________________

Results of previous diagnosis or therapy: ______________________________________

When did the problem first begin? ____

Has the problem: ☐ remained the same ☐ gradually worsened ☐ worsened quickly?

EDUCATIONAL HISTORY

Name of Current Preschool/School: ____

Grade: ______ Primary Placement:
☐ Regular Ed. Classroom
☐ Self-Contained Classroom (Full Day)
☐ Special Education (Part-Day)
☐ Other ______________________________

Teacher's Name: ____

Describe the child's progress in school: ____

____

In your opinion, does the child's speech/language problem have an effect on his/her school performance or school placement? ☐Yes ☐ No If yes, please explain:

____

Does the child receive speech-language therapy at school? ☐Yes ☐ No

If yes, please indicate the following:

- Name of Clinician: ____
- Length and frequency of sessions: ____
- Primary focus of therapy: ____

FAMILY HISTORY

Mother's Name: ______________________ Age: ______ Highest Degree/Grade: _____

Father's Name: _______________________ Age: ______ Highest Degree/Grade: _____

Siblings: Name: __________________ Age: ______ Highest Degree/Grade: _____

Name: ___________________ Age: ______ Highest Degree/Grade: _____

Name: ___________________ Age: ______ Highest Degree/Grade: _____

Name: ___________________ Age: ______ Highest Degree/Grade: _____

Others in the Home: ____
Name Relationship

____
Name Relationship

PREGNANCY AND BIRTH HISTORY

Did the birth mother have any illnesses or accidents during the pregnancy? □Yes □ No

Did the birth mother receive/take any prescribed medications while pregnant? □Yes □ No

If yes, what medications and for how long? ______________________________________
____

Where the medications used during the: □ first trimester □ second trimester □ third trimester?

Did the birth mother drink alcohol or use any illegal drugs while pregnant? □ Yes □ No

Were there any complications during the pregnancy? □Yes □ No

Were there any complications during the labor and/or delivery? □ Yes □ No

Was the baby's birth: □ premature □ term □ late?

Did the baby have difficulty with any of the following in the first 48 hours following birth?

□ breathing □ crying □ sleeping

□ sucking □ responding to noise □ other

Comments on any of the above: ____
____

How long did the baby remain in the hospital following birth? ______________________

DEVELOPMENTAL HISTORY

I have never been concerned about my child's developmental patterns. ☐ Yes ☐ No

I am concerned about my child's development because ____________________________
____

Please indicate the approximate ages at which each of the following occurred for the first time:

_____ Cooing	_____ Ask Questions	_____ Feed Self/Hands
_____ Babbling	_____ Sit Unassisted	_____ Feed Self/Utensil
_____ Single Words	_____ Stand Unassisted	_____ Toiled Trained
_____ Combine Words	_____ Walk Unassisted	_____ Dress Self

Is English the child's native language? ☐Yes ☐ No

If not, what is the child's native language? ______________________________________

How many languages are spoken in the home? _____ Which languages? _____________
____

MEDICAL HISTORY

General Health: ☐Excellent ☐ Good ☐ Fair ☐ Poor

Please indicate any ongoing medical conditions: _________________________________

Please indicate any regular medications: _______________________________________
____

Has the child ever been seen by any of the following specialists? Check all that apply:

☐ ENT Physician	☐ Psychologist	☐ Nutritionist
☐ Neurologist	☐ Behavior Specialist	☐ Orthodontist
☐ Psychiatrist	☐ Physical Therapist	☐ Other ____________
☐ Physiatrist	☐ Occupational Therapist	___________________

Please list previous surgeries/illnesses/injuries:

PROBLEM	DATES	COMMENTS

Please check all that apply and provide clarifying information under "Comment":

ILLNESS COMMENT	Y	N
Allergies		
Recurrent colds/flu/sore throat		
Dizziness		
Dental problems		
Frequent laryngitis/ hoarseness		
Epilepsy/seizure disorder		
Reading and/or spelling problems		
Other academic problems		
Attention Deficit Disorder (ADD)		
ADD with Hyperactivity (ADHD)		
Vision problems		
High fevers		
Kidney problems		
Swallowing/digestive disorders		
Respiratory difficulties		
Heart/circulatory problems		
Neurological disorders		
Cancer		
Endocrine/metabolic disorders (thyroid problems, diabetes)		
Viruses (HIV, Herpes)		
Connective Tissue Disorders (Lupus, Rheumatoid Arthritis)		
Frequent and/or intense headaches		
Measles		
Mumps		
Chicken Pox		
Meningitis		
Unusual fatigue/stress		
Mental illness		
Congenital disorders (list please)		

Please list names/approximate dates/reason for specialists:

Name: ____ Date: __________________________

Reason for Involvement: ____

Name: ____ Date: __________________________

Reason for Involvement: ____

Name: ____ Date: __________________________

Reason for involvement: ____

AUDIOLOGICAL HISTORY

Please check the appropriate column:

	Y	N
My child had 3+ ear infections between birth and 12 months of age.		
My child has had at least one ear infection which lasted more than 3 months.		
My child has been evaluated by an audiologist who determined that his/her hearing is within normal limits. Date of visit:_________		
My child has failed a hearing screening in school. Date of screening: ____		
My child has passed a hearing screening in school. Date of screening: ___		
I suspect my child has a hearing problem.		
My child prefers one ear over the other. If yes, which ear? □ R □ L		
My child has had tubes in his/her ears. If yes, when? _________________		
My child wears hearing aids. If yes, what type, and for how long?		

Comments: ____

____

____

____

SPEECH AND LANGUAGE HISTORY

Please check the appropriate column:

	Y	N
My child follows directions well.		
My child gives directions well.		
My child asks for help when needed.		
My child expresses himself/herself in a coherent manner that is understood by others.		
My child likes to have stories read to him/her. How long does he/she attend to the story? _________		
My child plays with age-appropriate toys appropriately.		
My child has failed a speech screening in school. Date of screening: ______		
My child has passed a speech screening in school. Date of screening: _____		
My child communicates primarily through whining/crying.		
My child communicates primarily through gesturing/pointing.		
My child tries to communicate through verbalizing, but cannot be understood.		
My child primarily uses one-word utterances to communicate.		
My child primarily uses two-word phrases to communicate.		
My child primarily combines 3+ words to communicate.		
My child uses proper sentence structure for most of his/her utterances.		
My child's communication efforts are easily understood by familiar persons.		
My child's communication efforts are easily understood by unfamiliar persons.		
My child frequently drools.		
My child has difficulty chewing his/her food.		
I am concerned about my child's speech (how well what he/she says can be understood).		
I am concerned about my child's language development (the content of what he/she says; how well he/she understands what others say).		

Overall, I would rate my child's speech intelligibility as:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Completely unintelligible

Comments: ____
____
____