**Speech-Language-Hearing Case History Questionnaire**

**Child Lives With:**
- _____ Birth Parents
- _____ Foster Parents
- _____ Other
- _____ Mother
- _____ Father
- _____ Adoptive Parents
- _____ Parent and Step-parent

Does child have siblings?  ____ Yes  ____ No

If yes, how many? ______________________________________________________

**Family History of Speech and Language Diagnoses:**  ____ Yes  ____ No

If yes, please explain: ______________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Children’s race/ethnic group:
- _____ Caucasian
- _____ Hispanic
- _____ African-American
- _____ Native American
- _____ Asian
- _____ Other

**Birth History**

How old was the mother when the child was born? ____________________________

How many months was the pregnancy? _________

Were there any complications that occurred either during the pregnancy or the birth process?  ____ Yes  ____ No

If yes, please describe._____________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Did the child go home with his/her mother from the hospital?  ____ Yes  ____ No

If child stayed at the hospital, please describe why and how long.________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Medical History

Does your child have any known medical diagnosis? ____________________________________________

Does your child have any known allergies? _____ Yes _____ No
_________________________________________ Seasonal ___________________________ Food
_________________________________________ Latex ___________________________ Dye
_________________________________________ Medication ___________________________ Other

Does your child have any dietary restrictions: _____ Yes _____ No
If yes, please explain:
____________________________________________________________________________
____________________________________________________________________________

Has your child had any of the following?

_____ Adenoidectomy  _____ Asthma  _____ Measles
_____ Tonsilitis  _____ Esophageal Reflux  _____ Mumps
_____ Tonsillectomy  _____ Vocal nodules/polyps  _____ Chicken Pox
_____ Frequent colds  _____ Seizures  _____ Encephalitis
_____ Sinusitis  _____ Head Injury  _____ Flu
_____ Ear infections  _____ High Fever  _____ Vision problems
_____ Ear tubes  _____ Scarlet Fever  _____ Sleeping difficulties
_____ Breathing Difficulties  _____ Meningitis  _____ Xerostomia (Dry Mouth)

Other medical condition(s): _____________________________________________________________

Other serious injury/surgery: ____________________________

Is your child currently (or recently) under a physician’s or specialist’s care? _____ Yes _____ No
If yes, why?
____________________________________________________________________________

Please list any medications your child takes regularly: ____________________________________________

____________________________________________________________________________

Has your child been or is he/she currently under the care of an orthodontist? _____ Yes _____ No
If yes, Please explain: ________________________________________________________________

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Developmental History

Please tell the approximate age that your child achieved the following developmental milestones:

- _______ Sat up
- _______ Crawled
- _______ Stood
- _______ Walked
- _______ Babbled
- _______ Used Single Words
- _______ Combined Words
- _______ Fed Self
- _______ Dressed Self
- _______ Toileted

Behavioral Characteristics

- _______ Cooperative
- _______ Attentive
- _______ Willing to try new activities
- _______ Plays alone for reasonable length of time
- _______ Separation difficulties
- _______ Easily frustrated/impulsive
- _______ Stubborn
- _______ Restless
- _______ Poor eye contact
- _______ Easily distracted/short attention
- _______ Destructive/aggressive
- _______ Withdrawn
- _______ Inappropriate behavior
- _______ Self-abusive behavior

Please list specific toys or activities that motivate your child:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Hearing

Did the child pass his/her newborn hearing screen? _______ Yes _______ No

Do you feel your child has a hearing problem? _______ Yes _______ No
If so, please describe: ________________________________________________________

Has he/she ever had a hearing evaluation/screening? _______ Yes _______ No
If yes, where and when? _____________________________________________________
What were you told? _________________________________________________________
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Oral Motor/Feeding

Please tell the approximate age that your child achieved the following feeding milestones:

____________ Drank from a sippy cup       __________ Consumed mashable table foods
____________ Drank from an open cup       __________ Consumed a variety of food textures
____________ Consumed solids

Does your child currently...

_____ Use a pacifier?
_____ Choke on food or liquids?
_____ Put toys, objects or clothing in his/her mouth?
_____ Brush his/her teeth and/or allow brushing?
_____ Hold food in his/her mouth?
_____ Sleep with mouth open, or is his/her mouth open at rest?
_____ Snore?
_____ Drool?
_____ Eat in a messy manner?
_____ Have difficulty with use of a straw or bottle?
_____ Suck his/her thumb?

Is he/she a picky eater? _____ Yes _____ No
If so, please explain:
__________________________________________________________________________
__________________________________________________________________________

Speech and Language

Does your child currently...

_____ Repeat sounds, words or phrases over and over?
_____ Understand what you are saying?
_____ Retrieve/point to common objects upon request (ball, cup, shoe)?
_____ Follow simple directions
_____ Respond correctly to yes/no questions?
_____ Respond correctly to who/what/where/when/why questions?
_____ Ask questions of others?
_____ Communicate his or her basic wants, needs, and feelings?
_____ Comment on daily activities, objects, and people within his or her environment?
_____ Participate in conversations with others?

Please check below any/all forms your child currently uses to communicate:

_____ Body language       _____ Sounds (vowels, grunting)
_____ Words (shoe, doggy, up) _____ 2 to 4 word sentences
_____ Sentences longer than four words _____ Other
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Do you feel your child has a speech/language problem?  _____ Yes  _____ No
If yes, please describe. ______________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Has he/she ever had a speech and language evaluation/screening?  _____ Yes  _____ No
If yes, where and when? _____________________________________________________
What were you told? _________________________________________________________
__________________________________________________________________________

Has he/she ever had speech/language therapy?  _____ Yes  _____ No
If yes, where and when? _____________________________________________________
What were you told? _________________________________________________________
__________________________________________________________________________

Is your child aware of, or frustrated by, any speech/language difficulties?________________

Do you feel your child’s speech and/or language difficulties are impacting his/her social
interactions with peers and/or adults?  _____ Yes  _____ No
If yes, please explain: ________________________________________________________
__________________________________________________________________________

Additional Information

Has your child received any other evaluation or therapy? (physical therapy, occupational
therapy, etc.)  _____ Yes  _____ No
If yes, where and when? _____________________________________________________
What were you told? _________________________________________________________
__________________________________________________________________________

What do you see as your child’s most difficult problem at home?____________________

What do you see as your child’s most difficult problem at school?___________________

What are you hoping your child will achieve through outpatient speech/language therapy?
__________________________________________________________________________
__________________________________________________________________________

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School History  
If your child is school-age, please answer the following:

Name of school and child’s grade level:______________________________

What are your child’s strengths and/or best subjects?______________________________

Is your child having difficulty with any subjects?______________________________

Is your child receiving any special services through his/her school? _____ Yes _____ No  
If yes, please describe.____________________________________________________

Has your child ever completed psycho-educational testing through the school system?  
_____ Yes _____ No  
If yes, please describe.____________________________________________________

Do you have any additional documentation to provide for us today? _____ Yes _____ No  
If yes, please describe or attach.____________________________________________