Speech and Language Services
1540 South 70th Street, Suite 101
Lincoln, NE 68506

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CASE HISTORY: Children Ages 0-7

Child's Name		Birthdate		Age		Gender	
Address		City, State, Zip					
Mother's Name		Email		Phone			
Father's Name		Email		Phone			
Emergency Contact		Relationship to child		Phone			
Referring Physician		Address					
Concerns regarding child's communication							
Previous or current diagnosis							
What services are you seeking from our clinic?							
How did you hear about Communication Works?							

FAMILY HISTORY

Child currently lives with		Relationship with siblings	
Child's favorite activities/toys/books			
Opportunities to be with other children		Primary language spoken in the home	
Stressful situations child has experienced in the last year			
Child's family members (e.g., mother, grandfather, brother) that have a history of:		Cognitive disability	
Speech challenges (e.g., stuttering, late talker, lisp		ADHD	
Reading, writing, or other learning challenges		Autism	
Mental illness		Hearing loss	

PREGNANCY/BIRTH HISTORY

Length of pregnancy		Mother's age at delivery		Birth weight	
Complications during pregnancy or at birth					

DEVELOPMENTAL/MEDICAL HISTORY (Please check all that apply)

	Serious illness or bodily injury		Appetite/eating/swallowing problems
	Head injury or concussion		Thumb sucking/pacifier past age two
	Surgeries:		Allergies/asthma/respiratory problems
	Physical disabilities		More than three ear infections/tubes in ears
	High fevers		Hearing loss/hearing aids/cochlear implants
	Seizures		Vision problems/eye glasses
	Medications/dietary supplements		Chronic conditions
	Difficulty with fine motor skills (e.g., eating, coloring)		Difficulty with gross motor skills (e.g., walking, running)
	Previous medical testing (e.g., CT scan, MRI, EEG, genetics)		
	Results of medical testing		

COMMUNICATION AND SOCIAL DEVELOPMENT

When did child:	Babble?		Say first real words?		Combine 2 words?	
Did child start talking & then stop adding new words/phrases?	No		Yes		If yes, when did this occur?	
What are the child's primary methods of communication at this point in time? Check all that apply.						

Cry/scream		Point/gesture		Sounds		Single words		Phrases		Sentences	

If child has fewer than 15 words, what are they?	
Check the word that best describes your child (take into account your child's current age):	

Gets confused; has difficulty following simple directions		Often		Sometimes		Rarely/never
Speech errors interfere with ability to be understood		Often		Sometimes		Rarely/never
Sounds like s/he is stuttering		Often		Sometimes		Rarely/never
Repeats what others say, but with no apparent meaning		Often		Sometimes		Rarely/never
Ignored, teased, or not accepted by other children		Often		Sometimes		Rarely/never
Separates from parent		With difficulty		Average		Easily
Reaction to cuddling or being touched		Pulls away		Average		Initiates
Plays with age level toys		In unusual ways		Appropriate		Creatively
Reaction to new toys, people, change in routine		Resistant		Average		Eager
Tends to ignore other people		Often		Sometimes		Rarely
Avoids eye contact		Often		Sometimes		Rarely
Disobedient/defiant/uncooperative		Often		Sometimes		Rarely
Shows aggression toward others (e.g., bites, hits, kicks)		Often		Sometimes		Rarely
Destructive toward objects (e.g., breaks toys on purpose)		Often		Sometimes		Rarely
Temper tantrums		Often		Sometimes		Rarely
Engages in self-injurious behavior (e.g., head banging)		Often		Sometimes		Rarely/never
Unusual body movements (e.g., spins, rocks, flaps hands)		Often		Sometimes		Rarely/never
Fearless		Often		Sometimes		Rarely
Fearful		Often		Sometimes		Rarely
Attention span		Distractible		Average		Attentive
Impulsive		Often		Average		Rarely
Has difficulty going to bed on time		Often		Sometimes		Rarely
Has difficulty sleeping through the night		Often		Sometimes		Rarely

OTHER SERVICES

Services that have been, or are still being provided by other agencies/persons.

Type of Service	Name of Provider or Agency	Times per Week or Month	Age service began	Age service ended
Speech therapy				
Physical therapy				
Occupational therapy				
Day care				
Preschool				
Psychologist				
Other				

Please provide medical information, the most recent speech and language reports, IEPs, IFSPs, and other documentation that will help us plan the most appropriate services for your child. You may email, fax, send the information with this form, or ask providing agencies to send the information directly to Communication Works. Thank you.

Signature of Person Completing Case History　　Relationship to Child　　Date

Please return this form and other documentation to Communication Works • 1540 South 70th Street, #101 • Lincoln NE 68506