Speech and Language Services

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Lincoln, NE 68506

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CASE HISTORY: Ages 8-18

Student's name:		Birthdate:		Age:		Gender:	
Address:		City, State, Zip:					
Mother's name:		Email:		Phone:			
Father's name:		Email:		Phone:			
Emergency contact:		Relationship:		Phone:			
Referring physician:		Name of clinic:		Phone:			
Student's strengths:							
Concerns that prompted the referral:							
What services are you seeking from our clinic:							
How did you hear about Communication Works?							

FAMILY HISTORY

Student currently lives with:		Primary language spoken in the home:					
Stressful situations student has experienced within the last year:							
Please identify family members (e.g., mother, grandfather, brother) that have a history of:							
	Speech challenges:		ADHD:				
	Reading, writing or other learning challenges:		Autism:				
	Cognitive disability:		Mental illness:		Hearing loss:		
Amount of time spent with technology each day	Gaming:		TV:		YouTube:		Texting:

PREGNANCY/BIRTH HISTORY

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

MEDICAL HISTORY

Head injury/concussion:	Age of occurrence:		Severity:		Cause:	
Medical testing (e.g., CT scan, genetics) and results:						
Syndromes (e.g., Down, Turner):						
Serious illnesses, surgery, or bodily injuries:						
Chronic conditions (e.g., asthma, allergies, seizures):						
Physical disabilities:						
Hearing/vision problems:						
Unhealthy eating habits (anorexia, bulimia, overeating):						
Self-injurious behavior:						
Medications:						
Other:						

COMMUNICATION/ACADEMIC/SOCIAL HISTORY (Check the word that best describes your student, considering your student's age)

Speech sound 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
Perseverates on ideas or preferred topics		Often		Sometimes		Rarely/never
Difficulty sequencing/organizing ideas to relate a story or event		Often		Sometimes		Rarely/never
Difficulty following directions or conversations		Often		Sometimes		Rarely/never
Difficulty starting or maintaining a conversation		Often		Sometimes		Rarely/never
Difficulty learning new things		Often		Sometimes		Rarely/never
Difficulty with reading comprehension		Often		Sometimes		Rarely/never
Difficulty with writing skills		Often		Sometimes		Rarely/never
Increased effort/time required to complete homework		Often		Sometimes		Rarely/never
Attitude toward school and learning		Negative		Indifferent		Positive
Difficulty attending/maintaining focus		Often		Sometimes		Rarely/never
Distractible/impulsive		Often		Sometimes		Rarely/never
Unorganized/lack of planning/difficulty completing tasks		Often		Sometimes		Rarely/never
Easily frustrated		Often		Sometimes		Rarely/never
Disobedient/defiant/uncooperative/resistant		Often		Sometimes		Rarely/never
Aggressive toward people (e.g., hits, pushes, kicks)		Often		Sometimes		Rarely/never
Destructive toward property (e.g., breaks items on purpose)		Often		Sometimes		Rarely/never
Has difficulty telling the truth		Often		Sometimes		Rarely/never
Makes poor choices at home and/or school		Often		Sometimes		Rarely/never
Fearless/overconfident		Often		Sometimes		Rarely/never
Indecisive/fearful/anxious		Often		Sometimes		Rarely/never
Unusual body movements (e.g., spins, rocks, twirls, flaps hands)		Often		Sometimes		Rarely/never
Avoids eye contact/tends to ignore others		Often		Sometimes		Rarely/never
Teased or not accepted by other kids		Often		Sometimes		Rarely/never
Has difficulty making/keeping friends		Often		Sometimes		Rarely/never

SERVICES (Please identify services that have been, or are still being provided by the school and other agencies/persons.)

Type of Service	Agency	Name of Provider	Times/week or month	Age or date service began	Age or date service ended
Speech therapy					
Special education					
Occupational therapy					
Physical therapy					
Psychologist					
After school care					
Other					

Previous or current diagnosis		Does your child have an established IEP?	

Current school		Grade		Classroom/homeroom teacher	

Please provide intake information and the most recent reports and documentation from the above agencies so we may plan appropriate services for your student. Thank you!

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Name of person completing case history	Relationship to student	Date