



Kidzspeech, LLC
Kirsten Cerroni, MS/CCC-SLP

Case History Form

Child's Name: _____ D.O.B. _____ Age: _____

Parents: _____

Address: _____

Phone: _____

Siblings and Ages: _____

Is there a family history of speech, language, hearing, or other learning problems?

Child's Physician: _____ Phone: _____

Physician Address: _____

Reason for Referral: _____

Medical History:

Check any past or present medical problems which may apply:

Ear infections _____ Asthma _____ Cleft lip or palate _____

Cerebral Palsy _____ Autism _____ Down Syndrome _____

Enlarged Tonsils/Adenoids _____ Snoring _____ Hearing Loss _____

Vocal Nodules _____ Feeding or Swallowing Problems _____

Genetic Disorder _____

Other _____

Medical Specialists seen:

(Check all which apply and give names, places, and dates if possible. A thorough medical history is necessary to assist in making an accurate diagnosis and appropriate recommendations.)

Neurologist _____

Audiologist _____

Psychologist _____

Speech Pathologist _____

Gastro-enterologist _____

Occupational Therapist _____

Allergist _____

Physical Therapist _____

Ear-Nose-Throat _____

Other _____

Hospitalizations/Surgeries:

W238N1690 Rockwood Drive • Suite 500 • Waukesha, WI 53188
clinic (262) 347-2222 • mobile (414) 507-9181 • fax (262) 347-2251

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Birth History:

Health of mother during pregnancy: _____
 Length of pregnancy: _____
 Type of delivery: _____ Vaginal _____ C-section _____ VBAC
 Were there multiple births during this delivery? _____
 Were any of the following used during labor and delivery:
 Pitosin _____ Forceps _____ Vacuum extraction _____
 Were there any complications or problems during delivery? _____
 Baby's condition at birth _____ Apgar Scores if known _____
 Birth Weight: _____
 Were there any problems after birth? _____
 Length of baby's hospital stay: _____

Developmental Milestones:

(Ages at which developmental milestones were achieved)

Motor:

_____ sat alone
 _____ crawled
 _____ walked

Speech:

_____ cooed (vocalized vowel sounds)
 _____ babbled (repetitive consonant-vowel combinations)
 _____ used jargon speech (made up words)
 _____ first word
 _____ two word combinations
 _____ phrases/sentences
 _____ followed simple directions

Toileting: _____ day time _____ night time _____ completely independent

Does your child seem to understand most of what is said to him/her? _____
 Can you understand most of what your child is saying? _____
 Can other people understand most of your child's speech? _____
 Does your child seem frustrated with his communication abilities? _____
 Is more than one language spoken in the home? _____
 Has your child ever had a Speech-Language evaluation before? _____

 Has your child's hearing ever been tested? (include date, location, and results) _____

Social Interaction:

How well does your child separate from parents: _____
 How well does your child interact with
 Siblings: _____

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Other children: _____

Adults: _____

Does your child exhibit any of the following behaviors:

- ____ Excessive temper tantrums
- ____ Aggressive/destructive behaviors
- ____ Self-abusive behaviors
- ____ Hyperactivity
- ____ Interrupted sleep
- ____ Poor eye contact
- ____ Doesn't appear to be listening even though his/her hearing seems fine
- ____ Doesn't use his/her index finger to point at things of interest
- ____ Crying or laughing for no apparent reason

Does your child exhibit any unusual behaviors not listed: _____

Sensory History:

Does your child demonstrate intense discomfort with any of the following:

- | | |
|---|-----------------------------|
| ____ certain noises | ____ clothing tags/textures |
| ____ food textures/or tastes | ____ having dirty hands |
| ____ walking barefoot | ____ wearing shoes |
| ____ certain smells | ____ touching certain items |
| ____ movement activities (swinging, spinning) | |

Does your child seem to seek out intense movement activities? (jumping, spinning) _____

Other: _____

Education/Daycare:

What type of school/daycare program is your child involved in? _____

Name/address/phone of school/daycare center _____

Grade/Type of class: _____

Teacher: _____

Days/Times of attendance: _____

Does your child have an IEP? _____

I appreciate your taking the time to fill out this form in as much detail as possible. It will greatly assist me in best helping you and your child.

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