FOR OFFICE USE ONLY
*SUPERVISOR'S INITIALS*_____
DATE OF EVAL. _____
TIME OF EVAL. _____
C.A.: _____

MERCY COLLEGE
Speech and Hearing Center
Phone: (914) 674-7742
Fax: (914) 674-7597

Case History Questionnaire
Child

THIS FORM MUST BE COMPLETED AND RETURNED BY _____ OR YOUR EVALUATION APPOINTMENT MAY BE FORFEITED. YOU CAN FAX IT OR MAIL IT BACK IN THE ENVELOPE PROVIDED. THANK YOU FOR YOUR COOPERATION.

In your own words, describe your child's communication problem. Please indicate when you first noticed the problem and if there have been any recent changes.

GENERAL INFORMATION

Child's Name: _____Date of Birth: _____

Address: _____

Home Phone: _____Business Phone: _____

Cell Phone: _____E-Mail Address: _____

Name of Person Filling Out the Questionnaire: _____

Relationship to Child: _____

Mother's Name: _____

Mother's Occupation: _____

Father's Name: _____

Father's Occupation: _____

Referral Source (e.g., teacher, doctor, etc.): _____

Referral's Name: _____

Address: _____

Contact Phone Number: _____

Permission to contact referral source? Yes ___No___ (If yes, please sign consent form)

FAMILY HISTORY

Sibling(s) Name(s): _____ Date of Birth: _____

_____ _____

_____ _____

_____ _____

Other people living in the home: Relationship to the child:

_____ _____

_____ _____

What is the child's primary language? _____

Are any other languages spoken in the home? _____

Are there any other family members who have received speech/language therapy services? If yes, please explain.

PRE-NATAL AND BIRTH HISTORY

Describe the mother's general health during the pregnancy. Were there any illnesses, complications, traumas, medication, etc.?

Length of pregnancy: _____weeks Child's Birth Weight: _____

Substances used during pregnancy: cigarettes___alcohol___drugs___none____

Vaginal delivery _____ Head first_____ Breech (feet or buttocks first)_____

Caesarean (C-section) _____ If a C-section was done, please explain why.

Were there any complications during or immediately following delivery? If yes, please explain.

Was the baby placed in an incubator? If yes, please explain why.

MEDICAL HISTORY

Describe your child's current health status.

Has your child suffered any of the following illnesses or conditions? If so, please provide age of occurrence.

Ear infections_____ Asthma_____

Convulsions_____ Seizures_____

Tonsillitis_____ High Fever_____

Other_____

List any allergies that your child has (including food and drug allergies):

_____

_____

Describe any accidents, head trauma, surgeries or hospitalizations that your child has had.

Is your child under a doctor's care? If so, for what condition? What medications, if any, is your child currently taking?

DEVELOPMENTAL HISTORY

Provide the approximate age at which your child did the following:

Sit up _____ Crawl_____ Stand_____

Walk_____ Become toilet-trained_____

Do you have any concerns about your child's development in any of the following areas?

Gross Motor (walking, running, physical activities) Yes_____ No_____

Fine Motor (use of pencil, manipulation of objects) Yes_____ No_____

Independent Functioning (eating, dressing self) Yes_____ No_____

If you checked "yes" to any of the above areas, please describe your concerns.

Briefly describe any other concerns you have regarding your child's development.

Has your child ever experienced feeding difficulties (e.g., reflux, sucking, swallowing, drooling, etc.)?
Yes_____ No_____
If yes, please describe.

SPEECH/LANGUAGE/HEARING HISTORY

Provide the approximate age at which your child did the following:
Babbled & vocalized (e.g., ooo-bababa)? _____
Said first word?_____What was your child's first word? _____
Began putting words together?_____
Began to use simple sentences to communicate (e.g., "Want drink.")? _____

How does your child currently communicate (e.g., gestures, verbally, etc.)?

Does your child follow simple commands? Yes_____No_____
Does your child seem to understand two and three-step directions? Yes_____No_____
Does your child seem to understand what is being said to him/her? Yes_____No_____
Can people outside the immediate family understand your child's speech? Yes_____No_____

Have your child's speech and language skills been tested in the past? Yes_____No_____
If so, when and where were they tested and what were the results?

Date of last hearing test? _____ Location of test? _____
Were the results normal? Yes_____No_____ If no, please explain.
Date of last vision test?_____Were the results normal? Yes_____No_____
If no, please explain.

SOCIAL HISTORY

Describe your child's personality. Would you describe your child as "quiet/shy" or "talkative/friendly"?

Describe how your child interacts with peers.

Describe how your child interacts with adults.

What are your child's favorite activities/hobbies?

EDUCATIONAL HISTORY

School_____

Current Grade_____

Teacher's Name_____

Contact Phone Number_____

Does your child have an IEP (Individualized Education Plan)? Yes_____No_____

If yes, what is the designated disability classification? _____

Is your child receiving any special services in school? Yes _____ No_____ If yes, please list the services.

List any support services/modifications provided in school.

Check any of the following conditions that are of concern to you about your child:

General intellectual level _____ Difficulty with planning and organization_____

Difficulty completing an activity _____ Difficulty adapting to change_____

Easily distracted_____ Difficulty expressing self_____

Inability to concentrate_____ Difficulty with written expression_____

Difficulty reading_____ Difficulty learning/remembering new information_____

Please include any additional information related to the above-noted conditions.

Has your child been tested by any other professionals (e.g., neurologist, developmental pediatrician, occupational therapist)? Yes _____No _____

If yes, please indicate:

Date of Test	Type of Evaluation	Name of Evaluator	Results/Recommendations

Please provide any additional information that might be helpful in the evaluation and/or remediation of your child's communication abilities.