PLEASE COMPLETE ONLY WHAT APPLIES TO YOUR CHILD.

LSU Health NEW ORLEANS
School of Allied Health Professions

Department of Communication Disorders, Speech Language Pathology
1900 Gravier Street, 9th Floor, New Orleans, La 70112

Child Case History Questionnaire

Today's date: _____
Child's Name _____
Sex _____ Birthdate_____ Age _____

Address _____

Phone_____ Email address: _____

Parent's Name:_____DOB_____

Birthplace_____ Highest Grade Completed in School _____

Occupation_____

Parent's Name:_____DOB_____

Birthplace_____ Highest Grade Completed in School _____

Occupation _____

Referred by: _____ Phone: (_____) _____

Reason for referral: _____

Statement of the Problem.

What have you been told is your child's main problem or diagnosis? And what has been done about it?

_____
_____
_____
_____

What do you expect from this visit?

_____
_____

What questions would you like answered from this evaluation?

_____
_____

Are you seeking an evaluation to get a communication device for your child? _____
Are you interested in speech therapy? _____

Medical History

Does your child have any disabilities? _____
Please describe_____
Check the illnesses which the child has had. Give the child's age and the severity of the illness.

Illness	**Age**	**Mild, Average, or Severe**
Measles		
Chicken Pox		
Mumps		
Frequent cases of the flu		
Scarlet Fever		
Croup		
Tonsillitis		
Bronchitis		
Ear Infections		
Allergies		
Seizures		
Whooping cough		
Meningitis		
Encephalitis		
Other (please specify)		

Were any of the illnesses followed by noticeable changes in the child's general behavior or in speech/language? _____

If so, please describe: _____

Has the child had any **visual or Hearing problems** within the past year? Yes___ No___
If so, please describe:
_____

Developmental History

At what age was your child able to:
Hold their head alone _____ Sat alone _____ Stood alone _____ Walked alone _____
Self-feed _____ with spoon _____ with fork _____
Toilet trained_____ daytime _____ nighttime _____
Rode tricycle _____ Rode bicycle _____
Is the child able to get desired objects/toys that are out of reach? _____
If so, how does the child typically do so? ____ Rolling ____ Crawling _____ Walking.
Does the child fall or lose balance easily? _____
Child's present weight: _____ Child's present height: _____
Does the child prefer their _____ right hand _____ left hand
Is the child awkward using their hands? _____
If so, please describe:
_____
Does the child have difficulty chewing or swallowing? _____
If so, please describe_____
Do they drool? _____

Motor Ability (please check all that apply):

Method of mobility:

_____ Walks Unassisted
_____ Walks Assisted
_____ Stroller
_____ Wheelchair

Most reliable movement patterns:

_____ Pointing.
_____ Raising Arm
_____ Eye Pointing/Looking
_____ Other: _____

Self-Help Skills

Does your child: Feed themself? ____ Dress themself? _____ Uses the toilet independently___
If not, does your child require: _____ Partial assistance _____ Complete assistance
Comments:_____
_____

Adaptive Equipment

Please check all adaptive equipment your child uses:
_____ Hearing Aid _____Glasses _____ Communication equipment _____ Walker
_____ Others (specify) _____

Social and Education Information

Does the child currently attend school, nursery school or daycare program? _____
Name of the present school: _____
Age entered _____Grade entered_____ Current grade _____
Teacher(s)_____
School performance: ___Good ___Average ___Poor
Who lives in the home with your child? _____

Communication

Please indicate all means of communication currently used:
(If possible, rank order from most to least frequently used; 1 being most frequently used, etc.)
Speech_____ Eye pointing/Looking _____ Vocalization _____
Spoken "yes-no" _____ Manual Signing _____ Gestural "yes-no" _____
Bodily Gestures _____ Communication Device _____ Facial Expression _____
During the first year, other than crying would you say that the child was a:
___silent baby ___a very quiet baby ____an average noisy baby ____a very noisy baby
At what age did the child:
Start to make cooing and babbling sounds? _____
Say their first words? _____ What were they: _____
Have a name for most everything? _____
Use two-word combinations (example "want cookie")? _____
Use more complex short sentences? _____
Did the child say one or two words and then go a long time before saying any new words? ____
Did speech/language learning ever seem to stop for a period? _____
If so, please describe: _____
Does the child seem to be aware of their speech/language difference? _____
If so, please describe: _____

How many words are in the child's average message?
____One word ____Two to three words ____Four to five words ___Five or more words

If there is additional information which you feel will help us to understand the child and his/her problem better, please describe:

_____
_____
_____

Please print name of person completing the case history

_____ Date _____