Professional Speech & Language Therapy, Inc.
Speech Therapy Services
1514 E. Cleveland Avenue, STE 200
East Point, GA 30344
Phone: (678) 608-9601 ● Fax: 1 (800) 420-4398

CHILD CASE HISTORY QUESTIONNAIRE

Please Print

Patient

Child's Name: _____ **D.O.B.** _____ **Age:** _____ **Sex:** **Male** **Female**

Address: _____ **Phone Number:** _____

City: _____ **State:** _____ **Zip:** _____

Mother's Name: _____ **Mother's Occupation:** _____

Business Address: _____ **Business Phone No.:** _____

Father's Name: _____ **Father's Occupation:** _____

Business Address: _____ **Business Phone No.:** _____

Siblings

Brothers and Sisters Name(s): _____ **Age:** _____

Brothers and Sisters Name(s): _____ **Age:** _____

Brothers and Sisters Name(s): _____ **Age:** _____

Brothers and Sisters Name(s): _____ **Age:** _____

Brothers and Sisters Name(s): _____ **Age:** _____

Doctor

Physician/Doctor's Name: _____ **Phone No.:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Referral Source: _____ _____

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Positive Traits, Concerns and History of Pregnancy & Birth

1) What do you believe to be your child's positive traits and strengths? _____

_____

2) What are your concerns regarding your child? _____

_____

3) What was the general health of the mother during pregnancy and birth? (List illnesses, accidents, medications, length of pregnancy, length of labor and birth weight). Also, were there any unusual conditions that may have affected the pregnancy of birth? _____

_____

_____

Ages of Developmental Milestones

4) Sat without support: _____ **Crawled:** _____ **Walked:** _____ **First words:** _____

Short Sentence (example: _____**)**

5) What is the primary language of the child? _____**Secondary language?** _____

Medical History

6) Medical history of child. Check all that apply:

Frequent ear infections: _____ **Tubes in ear(s):** _____ **Hearing problems:** _____ **Allergies:** _____

Vision problems: _____ **Seizures:** _____ **Unconsciousness:** _____ **Concussion:** _____

Hospitalizations/surgeries: _____

Please give details of any areas above checked: _____

_____

7) Please list all current medical problems, treatments, and medications taking: _____

_____

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Evaluated or Services Given

8) Has your child ever been evaluated by or received any of the following services:

Speech & Language Therapy: _____ Physical Therapy: _____ Occupational Therapy: _____

Specialist(s): Physician, Psychologist, Special Education: _____

When and who provided the service(s): _____

Adults & Children Living In the Home

9) List all adults and children living in the home:

NAME	AGE	RELATIONSHIP	OCCUPATIONS/SCHOOL/GRADE

Other Information

10) Is there any other information the therapist(s) should know in order to help your child? _____

_____

11) Who can we thank for telling you about our practice? _____
Child's Doctor:_____ **Address**_____

12) Describe in your own words what problem your child is having with speech, language, and/or hearing:
_____
_____
_____

13) Does your child have a formal diagnosis? Yes ___ No ____ If yes, what is it? _____

_____ _____
Signature of the Person Providing Information **Relationship**

_____ _____
Printed name of Patient's Parent/Guardian **Date**