



LKS & ASSOCIATES

Speech and Occupational Therapy

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lksandassociates.com / www.lksandassociates.com

SPEECH-LANGUAGE CASE HISTORY

Patient Name:
Date:
Person filling out questionnaire:
Relationship to child:

STATEMENT OF THE PROBLEM

Describe in your own words what problem your child is having with speech, language, and/or hearing:
List any other concerns you have regarding your child's development:
Does your child have a formal diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what is it? When was it made? By whom was it made?

SPEECH, LANGUAGE AND HEARING DEVELOPMENT

Did your child make babbling or cooing sounds during the first 6 months of life? Yes <input type="checkbox"/> No <input type="checkbox"/>
At what age did your child say his or her first word?
What were your child's first words?
Did your child keep adding words once he/she started to talk? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please explain:
At what age did your child begin using 2 and 3 word sentences?
Did speech learning ever seem to stop for a period of time? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain:



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Does your child talk: A lot <input type="checkbox"/> Occasionally <input type="checkbox"/> Never <input type="checkbox"/>				
Does your child prefer to: Talk <input type="checkbox"/> Gesture <input type="checkbox"/> Talk and Gesture <input type="checkbox"/>				
Does your child most frequently use: Sounds <input type="checkbox"/> Single words <input type="checkbox"/> 2-word sentences <input type="checkbox"/> 3-word sentences <input type="checkbox"/> More than 3-word sentences <input type="checkbox"/>				
List examples:				
Does your child make sounds incorrectly? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, which ones?				
Does your child hesitate, "get stuck," repeat or stutter on sounds or words? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe:				
Describe any recent changes in your child's speech:				
Can your child tell a simple story? Yes <input type="checkbox"/> No <input type="checkbox"/>				
How well can your child be understood by the following individuals? Check the boxes that apply.				
	Always	Mostly	Sometimes	Rarely
Parents				
Siblings				
Teacher(s)				
Friends				
Strangers				
Does your child seem to understand what you say to him or her? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please explain:				
Does your child consistently answer to his/her name? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Does your child make appropriate eye contact with: Adults <input type="checkbox"/> Other children <input type="checkbox"/>				
Does your child follow simple commands? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe/give examples:				
Does your child ever have trouble remembering what you have told him or her? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain:				



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Does your child enjoy looking at books? Yes No

How often do you read to your child?

DEVELOPMENTAL HISTORY

Is your child: Biological Foster Adopted

Did the mother have medical problems during the pregnancy? Yes No
If yes, please describe, including medical attention:

Did the mother take any prescription and/or nonprescription medication during this pregnancy? Yes No
If yes, what kind(s):

Was your child full-term? Yes No
If no, what was the gestational age?

Was your child's delivery normal? Yes No
If no, please explain:

Was your child's delivery via caesarian? Yes No
If yes, please give the reason:

How long were the mother and child in the hospital?

You child's weight at birth?

Any birth injuries?

What special medication attention or treatment did your child receive at birth, if any?

Was your baby: Breast-fed Bottle-fed
If breast-fed, for how long?

Any difficulties transitioning from breast to bottle? Yes No
If yes, please describe:

What was your child's age when weaned off the bottle?

Were there any feeding difficulties during infancy? Yes No
If yes, please describe:



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What was your child's weight at one year old?
What is your child's present weight?
What age did your child begin puree foods (e.g., rice cereal, stage I jar foods)?
What age did your child begin soft chewable food?
What age did your child begin table food?
Did your child have difficulty transitioning to different food textures? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain:
Does your child have a limited diet due to "picky eating"? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe:
Does your child have any food allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list:
Does your child have any known gastrointestinal issues? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain:
Does your child: Finger feed <input type="checkbox"/> Use a fork <input type="checkbox"/> Use a spoon <input type="checkbox"/> Use an open cup <input type="checkbox"/> Use a straw <input type="checkbox"/>
Is adult assistance needed with feeding your child? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain:
Has your child ever choked on solid foods? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child cough on liquids? Yes <input type="checkbox"/> No <input type="checkbox"/>
Can your child chew well? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child drool? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when?
Did your child use a pacifier? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, age weaned off pacifier:
Does your child continue to mouth objects? Yes <input type="checkbox"/> No <input type="checkbox"/>
Did your child suck his/her thumb/fingers? Yes <input type="checkbox"/> No <input type="checkbox"/>



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If yes, until when?																				
Does your child suck on his/her hair/clothing/blanket/etc? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what?																				
Does your child resist tooth brushing? Yes <input type="checkbox"/> No <input type="checkbox"/>																				
Does your child like taking a bath? Yes <input type="checkbox"/> No <input type="checkbox"/>																				
Does your child like swings? Yes <input type="checkbox"/> No <input type="checkbox"/>																				
Does your child like parties? Yes <input type="checkbox"/> No <input type="checkbox"/>																				
Does your child like rough housing? Yes <input type="checkbox"/> No <input type="checkbox"/>																				
Does your child prefer to primarily play: Alone <input type="checkbox"/> With other children <input type="checkbox"/> With older children <input type="checkbox"/> With younger children <input type="checkbox"/> With adults <input type="checkbox"/>																				
Is your child overly sensitive to loud sounds? Yes <input type="checkbox"/> No <input type="checkbox"/>																				
Is your child overly sensitive to bright lights? Yes <input type="checkbox"/> No <input type="checkbox"/>																				
Is your child overly sensitive to tags on clothing? Yes <input type="checkbox"/> No <input type="checkbox"/>																				
When did your child do the following:																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Activity</th> <th style="width: 25%;">Age</th> <th style="width: 25%;">Activity</th> <th style="width: 25%;">Age</th> </tr> </thead> <tbody> <tr> <td>Sat up:</td> <td></td> <td>Ran:</td> <td></td> </tr> <tr> <td>Crawled:</td> <td></td> <td>Bladder trained:</td> <td></td> </tr> <tr> <td>Stood:</td> <td></td> <td>Bowel trained:</td> <td></td> </tr> <tr> <td>Walked:</td> <td></td> <td>Night trained:</td> <td></td> </tr> </tbody> </table>	Activity	Age	Activity	Age	Sat up:		Ran:		Crawled:		Bladder trained:		Stood:		Bowel trained:		Walked:		Night trained:	
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Sat up:		Ran:																		
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Stood:		Bowel trained:																		
Walked:		Night trained:																		
Which hand does your child use more frequently? Right <input type="checkbox"/> Left <input type="checkbox"/> No preference <input type="checkbox"/>																				

FAMILY HISTORY

Are there any members of your immediate family that have been diagnosed with any of the following:

DIAGNOSIS	FATHER	MOTHER	SIBLING
Learning Disability			
Dyslexia			



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Speech and Language Delay/Disorder			
Sensory Processing Disorder			
Auditory Processing Disorder			
ADD/ADHD			
Autistic Spectrum Disorder/PDD			
Other, please explain:			

MEDICAL HISTORY

Please list age, type of treatment, and/or number of recurrences next to those that apply

ILLNESS	AGE	TREATMENT	RECURRENCE
Allergies			
Asthma			
Chronic Colds			
Dental Problems			
Ear Infections			
Orthodontia			
Seizures			
Tonsillitis			

Describe any other illnesses, accidents, injuries, and hospitalizations of your child (include child's age):

If your child underwent any surgery, please describe (include date of surgery and surgeon's name):

Is your child's health: Good Fair Poor

Is your child now under medical treatment or on medication? Yes No
If yes, please explain:

Describe any speech, language, hearing, OT, PT, psychological, special education services, tutoring that your child is receiving/has received.



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TYPE OF THERAPY	THERAPIST	FREQUENCY	PLACE (PRIVATE/SCHOOL)	GROUP OR INDIVIDUAL	DURATION (E.G. AGE 3-5)

MEDICAL EXAMINATION HISTORY

EXAMINATION	MONTH	YEAR	DOCTOR	RESULTS
Last Physical Exam:				
Last Vision Test:				
Last Hearing Test:				
Other: _____				
Other: _____				
Other: _____				

Did/does your child wear a hearing aid? Yes No
If yes, please explain:

Did/does your child wear glasses? Yes No
If yes, please explain:

EDUCATIONAL HISTORY

Does your child attend? Daycare Preschool Kindergarten Grade School

Name of school:

Grade/Level:

In school, does your child do: Average Below Average Above Average

What are your child's best subjects?



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Has your child repeated a grade? Yes No
If yes, which one(s)?

What is your impression of your child's learning abilities?

What is your impression of your child's social skills?

Does your child display any behavioral or attentional issues at school?