Boston Children's Health Physicians
Until every child is well™
formerly CWPW

Child Case History Form

General Information

Name: Date of Birth:

Address: Phone:

City: Zip Code:

Does the Child Live With Both Parents?

Mother's Name: Age:

Mother's Occupation: Business Phone:

Father's Name: Age:

Father's Occupation: Business Phone:

Referred by: Phone:

Address:

Pediatrician: Phone:

Address:

Family Doctor: Phone:

Address:

Brothers and Sisters (include names and ages):

What languages does the child speak? What is the child's dominant language?

What languages are spoken in the home? What is the dominant language spoken?

(continues)

With whom does the child spend most of his or her time?

Describe the child's speech-language problem.

How does the child usually communicate (gestures, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

What do you think may have caused the problem?

Has the problem changed since it was first noticed?

(continues)

Is the child aware of the problem? If yes, how does he or she feel about it?

Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions?

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Are there any other speech, language, or hearing problems in your family? If yes, please describe.

(continues)

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.).

Length of pregnancy: Length of labor:

General condition: Birth weight:

Circle type of delivery: head first feet first breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Asthma	Chicken pox	Colds
Croup	Dizziness	Draining ear
Ear infections	Encephalitis	German measles
Headaches	High fever	Influenza
Mastoiditis	Measles	Meningitis
Mumps	Pneumonia	Seizures
Sinusitis	Tinnitus	Tonsillitis
Other		

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

Describe any major accidents or hospitalizations.

(continues)

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify.

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl	Sit	Stand
Walk	Feed self	Dress self

Use toilet

Use single words (e.g., no, mom, doggie)

Combine words (e.g., me go, daddy shoe)

Name simple objects (e.g., dog, car, tree)

Use simple questions (e.g., Where's doggie?) _____

Engage in a conversation _____

Does the child have difficulty walking, running, or participating in other activities that require small or large muscle coordination?

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing)? If yes, describe.

(continues)

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds).

Educational History

School: Grade:
Teacher(s):

How is the child doing academically (or pre-academically)?

Does the child receive special services? If yes, describe.

How does the child interact with others (e.g., shy, aggressive, uncooperative)?

(continues)

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals.

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form:

Relationship to client:

Signed:_____ Date: