



Integrating Children and Knowledge of Washington, Inc.

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CHILD CASE HISTORY

Child's Name: _____ Date of Birth: _____

Address: _____

City: _____

State/Zip: _____

Mother's Name: _____

Phone: W: _____

E-Mail: _____

Phone: H: _____

Father's Name: _____

Phone: W: _____

E-Mail: _____

Phone: H: _____

Referred by: _____

Pediatrician: _____

Phone: _____

Address/Location: _____

Referred by: _____

GENERAL INFORMATION:

Primary Language: _____ Second Language: _____

What language is spoken at home?: _____

Areas of concern:

Articulation: _____

Receptive Language Delay: _____

Fluency (Stuttering): _____

Expressive Language Delay: _____

Behaviors: _____

Reading Difficulties: _____

Drooling: _____

Voice: _____

Other: _____

Describe, in your own words, your child's speech-language, or behavioral problems or concerns:

When was the child's hearing last tested?: _____ Results: _____

How does your child typically communicate with you or others?

Gestures: _____ Sign Language: _____ Babbling: _____

Single words: _____ Short phrases: _____ Sentences: _____

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed? How?

Have any other specialists (physicians, psychiatrists, teachers, therapists, etc.) seen the child? ____ If yes, who and when? What were their conclusions or recommendations?:

Are there any other speech, language, or hearing problems in the history of your family (Include siblings, parents/grandparents, aunt/uncle, and first cousins)?: ____ Please describe:

PRENATAL and BIRTH HISTORY:

Mother's health during pregnancy: _____

Length of pregnancy: _____ Length of labor: _____

General condition of baby: _____ Birth weight: _____

Type of birth: head first ____ feet first ____ breech ____ Caesarian ____

Any oral/facial anomalies? (e.g., cleft palate, cleft lip, etc.): _____

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

MEDICAL HISTORY:

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

Allergies _____ Asthma _____ Chicken Pox _____

Ear Infections _____ Encephalitis _____ Headaches _____

High Fever _____ Influenza _____ Pneumonia _____

Seizures _____ Tonsilitis _____ OTHER _____

Any other information concerning health?

Any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)?:

Any allergies (including medications, food, environmental, etc.)?:

Is your child on any medications?: ____ If yes, what type and for what?

Provide the approximate age your child began to do the following activities:

Crawl: _____ Sit: _____ Stand: _____ Walk: _____

Feed self: _____ Dress self: _____ Use toilet: _____

Does your child follow basic directions (e.g., "Go get your shoes," "Find your bear," "Come here," etc.)? _____

What does your child do if he/she is angry or frustrated?

How does your child communicate his/her wants or needs (e.g., requesting something through gestures, crying, words, sentences, etc.)?

SCHOOL:

What school does your child attend?: _____

If in special education classes, please specify _____

Grade: _____ Teacher: _____

Strengths: _____

Weaknesses: _____

Any other recent testing that has not been covered?:

How does the child interact with peers?

Any other information we should know about your child?

Do we have permission to contact your child's teacher, therapist(s) or other professionals currently working with your child (you will be informed if this occurs)?

Yes ____ Signature: _____

No ____

Professional(s):

Contact #:
