Integrating Children and Knowledge of Washington, Inc.
5818 Conway Road Bethesda, MD 20817
P: 240.475.1626 F: 301.897.0819 E: icanofwashington@hotmail.com

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: ____
Fluency (Stuttering): _____
Behaviors: _____
Drooling: _____
Receptive Language Delay: _____
Expressive Language Delay: _____
Reading Difficulties: _____
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 #:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________