Indiana University
Speech & Language Clinic

Early Childhood History Form (Birth to Five Years)

General Information

Child Information	
Child's name:	**Date of Birth:**
Address:	**Phone:**
Parent/Guardian Information	
Guardian/Parent name:	**Parent/Guardian Name:**
Phone number:	**Phone number:**
Referral Information	
Referred by:	**Relationship to Child:**
Address:	**Phone:**
Doctor Information	
Child's Doctor:	**Phone:**
Address:	**Fax:**
School/Specialist Information	
Daycare/preschool name and teacher:	**Phone:**
Address:	**Fax:**
Other specialists:	**Phone:**
Address:	**Fax:**

Home, Family & Child Information

Please briefly describe your child (in one to two sentences).
Please list those who live in home (include name, age and relationship to your child):
What language(s) does your child speak?

What language(s) are spoken in the home?
What activities does your child enjoy?
In general, what are your child's strengths?
In general, what is challenging for your child?
How does your child usually communicate (gestures, single words, short phrases, sentences)?

Speech/Language or Communication Concern

Describe your child's speech/language or communication concern (what brings you to the clinic?):
When was the concern first noticed? By whom?
Has the problem changed since it was first noticed?
Is your child aware of the problem? If yes, how does he or she feel about it?
Have any other speech/language pathologists seen your child? Who and when? What were the conclusions or suggestions?
Have any other specialists (physicians, psychologists, special education teachers, occupational therapist, physical therapists, etc.) seen your 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.

Prenatal and Birth History

Mother's general health during pregnancy (please list any complications, illnesses or other pertinent information).
Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History

Has your child had his or her vision and hearing screenings completed? (If so, provide approximate date and results):
Please list any medical illnesses or conditions your child has had (ear infections, allergies, asthma, colds, dizziness, influenza, etc.) and the approximate age when the child suffered with the illness.
Please list any surgeries that your child has had and approximate date of surgery (e.g. tonsillectomy, P.E. tube placement, etc.)
Please describe any major accidents or hospitalizations.
Is your child taking any medications, if yes, please identify.
Have there been any negative reactions to medications? If yes, please describe.

Developmental History

Did your child or does your child currently have any difficulty crawling, walking, running or participating in other activities? If yes, please describe.
Does your child have any difficulty pushing buttons, turning pages, coloring, or manipulating small objects? If yes, please describe.
Are there or have there ever been any feeding problems (e.g. problems with sucking, swallowing, drooling, chewing, etc.)? If yes, describe.
Describe the child's response to sound (e.g. responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.)?

Please provide any other information that would be helpful in evaluating your child's speech and language.
Please list any additional questions or concerns you may have.

Please sign the form below if you consent to an evaluation.

Person completing this form:	**Relationship to the child:**
Signature:	
Date:	

Early Childhood Case History Form

Date Reviewed:

Student Clinician/SLP:

Date of Diagnostic: