Help Me Speak LLC
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Child's Full Name:____

Name by which client is called: ____

Address: ________________________ Date of Eval: _____________

________________________ Client's Home Phone #: ______________

Parents: __________________________ Cell Phone #: ______________________

DOB: __________________ Age: _________________

Siblings: _________________________ Gender: ____ Age: _________
Siblings: _________________________ Gender: ____ Age: _________
Siblings: _________________________ Gender: ____ Age: _________

What language(s) is/are spoken at home? ______________________________________
By whom? ____

Who referred you to **Help Me Speak**? ____

What are your main concerns that bring you to **Help Me Speak**: ____________________
____
Have you discussed these concerns with a professional?___ If so, with whom? doctor teacher other _______
Results of this conversation? ____

School Name: _________________________________ Teacher: __________________
School SLP: _______________________

List any medical diagnoses your child has & the 1st date given: _____________________

____

What do you hope to accomplish by coming to **Help Me Speak**? ___________________
____

Person completing form________________ Relationship to child_____________

PRENATAL AND BIRTH HISTORY:

Check any that apply:

During pregnancy:

___Excessive vomiting ___Hemorrhaging ___X-ray treatments
___Illnesses (e.g. German Measles) ___Medications___RH incompatibility
___Drug use ___Smoking ___Previous miscarriages _#
___Alcohol use ___Trauma/injuries ___High blood pressure
___Excessive weight loss ___Excessive wt gain ___Diabetes
___Gestational diabetes ___Premature rupture of membranes
___Hospitalization or bed rest ___Low platelets ___Other

Describe any maternal health problems (listed above or others) during pregnancy. Please list at **how many weeks** in your pregnancy each occurred.

____
____
____
____

Length of pregnancy _______ Birth Wt _____________
Describe delivery ____
General health of child at birth ____
Describe any Medical issues at birth: ____________________________________
____
____
____

Was your child in the NICU? __Y__N Which hospital? _________________________
Dates/ length of stay: ____
If so, please explain reason for admission & course of stay: _______________________
____
____

Date of discharge: _________________ To where? Home children's hospital________
Other___________

MEDICAL INFORMATION:

Does your child have a history of Upper Respiratory Infections ? Y or N
How many?_______ At what ages did they occur? ________________________

Does your child have a history of ear infections, otitis media, or uninfected fluid in the middle ear? _____ In which ear? R L Both How many? ____
At what ages did they occur? ____ How long did each ear problem last? _____________
____
What medications were prescribed? ____
____

Has your child ever been treated by an ear, nose, and throat specialist? Y or N
Who? ______________________________ When? ________________________
Does your child have tubes? Y or N
At what age were they placed? ________ By Doctor: _____________
Are they still present? Y or N
Are your child's tonsils/adenoids still present? Y or N
If not, when were they removed? ______________________ At what age? ___________

Allergies?____________________ Sinus problems? _____________________________
Treatment for above? ____
Food allergies?____

Or sensitivities? ____

DEVELOPMENTAL HISTORY:

At what age did your child develop:

1st tooth? _________ Baby teeth within normal limits? Y or N
Lost at what ages?_______
Any lost early due to injury? ____________
Orthodontic care? Y or N n/a
What type?____

At ***what age*** did your child develop: (please list ages)

Head support____ Reach & grasp____ Rolling (back to tummy)_____
Rolling(tummy to back)____ Sitting alone _____ **Crawling________ # months? ____
Standing alone____ Walking _____ Potty trained______
Climbing stairs____ Finger foods____ Use spoon ____
Undressed self____
Babbling: reduplicated (e.g. mamamama) _____ variegated (e.g. badagada) ____
Jargoning (e.g sounds like foreign language) ____ First word _____ Use single words ______
Use 2 words together ____ Talking in sentences _____

Handedness: R or L or not yet established

Is your child overly awkward or clumsy? Yes___ No____

EARLY FEEDING HISTORY:

Breastfed? Y N How long?____
Bottle until what age?____
Formula or breast milk in bottle? ____
Excessive length of time to drink a bottle? ______________________________________
Regurgitation of liquids or solids through the nose? _______________________________
Describe any other early feeding problems(during birth-6 mo):
____
____
____
Choking or gagging?____
On what food textures? ____
Colic?__________Reflux? _______________Describe each: _________________________
____
Special formula?____
Describe transition to baby food & finger food :____
____
At what age?:____________

Has your child ***ever*** or does your child ***currently***: (at what ***ages***)
Mouthed toys? Y N If so, what types? ______________________
(list **ages** for each used) Fingers? ___ Blankets? ____ Thumb?____ Pacifier? ____ Other?_____
How long?__________________

ORAL BEHAVIORS:
Mouth breathing? Y N while watching tv, in car, etc?

Teeth grinding? Y N Bite fingernails or cuticles? Y N Chew on: pencils erasers knuckles blanket fingers other_______
Lick lips excessively? Y N Lips chapped? Y N Chew gum excessively? Y N
Prop chin or head on palm or fist? Y N

EATING HABITS:

glasses liquid with meals? ______ Wash down food? Y N
Fast or slow eater? Chew food adequately? Y N Burp excessively after meals? Y N
Digestive problems? Y N __________ Resist difficult to chew foods? ____________

Is your child a picky eater? ___yes ___no

Food preferences? Please list **10 or more** Proteins: (e.g. meats, poultry, fish, & dairy)
____
____
Please list **10 or more** Fruits/Vegetables:
____
____
Please list **10 or more** Carbs:
____
____
Food dislikes? ____
____
Favorite tastes/flavors? ____
Preferred textures? ____
Preferred temperature? ____
Special diet/food restrictions? ____
Other? ____

SPEECH AND LANGUAGE DEVELOPMENT

13. Please list & describe each kind of sounds your child made before one year of age – cooing prolonged vowel sounds, babbling repeated syllables, squealing, etc.

14. Was there anything unusual about the sounds your child made during this period? If “yes”, please explain.

15. At what age did your child say his / her first real word? Word(s): __________

16. Did your child continue to add new words on a regular basis? If “no”:

a. How often did your child add a new word?

b. Did your child frequently use another way to communicate?

17. Did your child’s speech or language development seem to stop for a time? If “yes”:

a. When and **why** do you think it stopped?

b. How did your child communicate with you during this time?

18. How many different words is your child saying now?

19. Do you consider your child to be talkative or quiet?

20. How does your child usually let you know what he/ she wants?

If you answer "pointing" or "gesturing":
a. Does your child try to talk in combination with pointing?

b. does anyone in the family talk for your child or interpret his / her gestures?

21. Has your child ever talked better than he / she does now? If "yes", please explain.

22. What concerns do you have about the way your child's tongue or mouth works for speech or for eating? please describe.

23. What have you done to help your child learn to talk?

24. Has anything about your child's speech or language development seemed unusual to you? If "yes", please describe.

25. How much time does your child spend with other children?

26. Does anyone in the family have a history of any speech or language problems? If "yes", please describe.

COMPREHENSION AND UNDERSTANDING

When comparing your child to children of the same age:

27. Is your child easily confused when there are many things taking place around him / her? If "yes", please explain.

28. How does your child respond when you give him / her directions?

29. How does your child respond to simple questions?

30. How would you describe your child's intelligence or thinking skills?

31. List any other specialists who have seen your child:

Medical

Hearing

Listed below are words that young children might understand or say. IF your child not yet using *2-3 word combinations*, please put a *check* beside those words you think your child *understands*. *Circle* the words your child *says* when he / she talks to you. (138)

all
all gone
apple
arms
baby
babysitter's name
ball
balloon
banana
bear (teddy)
belly / tummy
big
bike
bird
book
boots
boy
bug
bunny
bye / bye-bye
candy
car
cat / kitty
chair
cheese
choo-choo
go bed
go bye-bye
go night-night
go out

church
clock
coat
cold
comb
cookie
cracker
cup
dada / daddy
diaper
dirty
dog / doggie
don't
done
down
drink
ears
eat
eat cookie
eyes
fall down
feet
fingers
flower
girl
go
grandma
grandpa
gum
hair

hands
hat
hi
horse / horsie
hot
hot dog
huh?
I
in
key
legs
little
mama / mommy
McDonald's / other
me
milk
mine
more
more cookies
mouth
night-night
no
nose
old
on
out
paper
phone
pizza
please
potty
purse
rock

see
shhhh
shirt
shoe
sit / sit down
sky
sleep
snow
so big
sock
spoon
stick
stop
stove
swing
teeth
thank you
thirsty
tissue
tired
toes
toy
truck
TV
uh-oh
under
up
want
wet
what
what's that
yes
you
yucky

List the names of family members, friends, or pets your child understands and circle the ones he/she says.

List any other words your child understands and circle what he/she says.
List any words that your child can write, if any.

COMMUNICATION STATUS:

How would you describe your child's current communication ability? (check all that apply)

____Almost never communicates
____Sometimes communicates
____Communicates frequently

____It is *very* easy for me to understand my child when I know the topic of conversation.
____It is *fairly* easy for me to understand my child when I know the topic of conversation.
____It is *difficult* for me to understand my child when I know the topic of conversation.

____It is *very* easy for me to understand my child when I don't know the topic of conversation.
____It is *fairly* easy for me to understand my child when I don't know the topic of conversation.
____It is *difficult* for me to understand my child when I don't know the topic of conversation.

____My child is usually understood by other people who don't know him/her well.
____My child is usually NOT understood by other people who don't know him/her well.

Please describe how your child communicates: ________________________________
____
____
____

Which of the following best describes your child's speech?
___easy to understand
___difficult for parents to understand
___difficult for others to understand
___almost never understood by others
___different from other children of the same age

Which of the following statements best describes your child's reaction to his/her speech?
___ Is easily frustrated when not understood
___Does not seem aware of speech/ communication problem
___Has been teased about his/her speech
___Tries to say sounds or words more clearly when asked
___Is successful in saying sounds or words more clearly when he/she tries

Is your child aware of his/her communication difficulties? ___yes ___no

If Yes, how does this awareness impact on his/her social/emotional status? ___________
____
____

Does your child have difficulty producing certain sounds? ___yes ___no
If so, which ones are difficult? ____

Does your child hesitate and/or repeatedly say sounds or words? ___yes ___no
If so, which ones? ____

Does your child "get stuck" when attempting to say a word? ___yes ___no
Explain: ____

Indicate your agreement with the following statements (circle one choice):

1. My child is able to communicate effectively to express pleasure or displeasure.
Strongly disagree Disagree Not Sure Agree Strongly Agree

2. My child is able to communicate to get help when needed.
Strongly disagree Disagree Not Sure Agree Strongly Agree

3. My child's biggest communication priority is to request things he/she needs.
Strongly disagree Disagree Not Sure Agree Strongly Agree

4. My child's biggest communication priority is to get or give information (e.g. ask/answer questions)
Strongly disagree Disagree Not Sure Agree Strongly Agree

5. My child's biggest communication priority is to initiate & maintain conversations.
Strongly disagree Disagree Not Sure Agree Strongly Agree

A typical day for my child is: ____
____
____
____
____
____

Please list any of your child's achievements that are especially important to him/her or you:
____
____
____
____
____

AUGMENTATIVE COMMUNICATION/ASSISTIVE TECHNOLOGY:

Has your child in the past or does he/she currently use an augmentative communication device or any assistive technology at home or at school? ___Yes ____No

If he/she has used a device in the past only, briefly explain why it is not currently used:
____
____
____

Who evaluated your child for this augmentative communication device/system?
____
____

HEARING HISTORY:

Does your child say "huh" or "what" at least 5 or more times per day? __Yes __No
Do you ever question your child's ability to hear normally? __Yes __No
If yes, please explain: ____
____

Is your child easily distracted? __Yes __No
Does your child have difficulty following directions? __Yes __No

When was the last time your child's hearing was checked? __within the last year
__1-3 years ago
__4+ years ago

Where? ____
By Whom? ____
Phone: _______________
Results ____

SOCIAL/ EMOTIONAL DEVELOPMENT:

Check behaviors that you feel best describes your child:

__Overly active
__Overly quiet
__Excessive tantrums
__Destructive
__Very shy
__Perfectionist
__Friendly, outgoing
__Imaginative & creative
__Plays well with other children
__Prefers older children
__Prefers younger children
__Defiant
__Easily controlled /Passive
__Nervous
__Dependent upon routines
__Difficulty separating from parent
__Thumb-sucking
__Drooling
__Teeth grinding
__Mouth breather
__Interrupted/Unusual eating habits
__Interrupted/ Unusual sleeping habits

Please describe any discipline problems you have with your child: __________________
____
____

Describe any evaluations or therapy for behavior or emotional difficulties: ____________
____
____

What method of discipline do you use? ______________________________________

What method of discipline does your spouse use? ________________________________

INTERACTION AND COMMUNICATION DEVELOPMENT

Do any of the following describe your child as an *infant, toddler, or young child*? If "yes", **please explain**. **In *relation to each question*, please state your child's *age at that time*.**

1. Was your child ever separated from you for a long time?

2. Did your child require any/frequent hospitalization?

3. Did your child resist cuddling?

4. Was your child often difficult to calm?

5. Was your child often colicky?

6. Did your child seem very restless?

7. Did your child seem very inactive?

8. Was your child nonresponsive when you "talked" with him / her?

9. Did your child often avoid eye contact with you or others?

10. Did your child often play with toys in an unusual manner? How?

11. Did your child use gestures to communicate? How?

12. Did your child show interest in the people and things around him / her? If "no", please explain.

THERAPEUTIC INFORMATION:

Please list some things that your child **really likes and dislikes** in each of the following categories: (***We use this section for planning activities in therapy***)

Toys: Likes- ____

____

Dislikes-____

____

TV Shows: Likes-____

____

Dislikes-____

____

Places to Go: Likes-____

____

Dislikes-____

____

Activities: Likes-____
____
Dislikes-____
____
Other Special Interest or Hobbies: _______________________________________
____
Dislikes-____
____

PLAY BEHAVIORS:

Please list from 1-5 the type of play your child likes to engage in most often. (5=most often 1=least often)

__Putting toys in mouth __Banging toys together __Throwing toys
__Shaking toys __Pushing/pulling toys __Role-playing
__Uses one object for another __Games with rules __Rough & tumble play
__Appropriate use of objects __Make believe games __Looking at books
__Acting out familiar routines __Computer games __Other: _________

What is the average length of time your child can play at one activity? _______________

Which activities seem to hold your child's attention for the longest periods of time?
____

Which activities do not seem to hold your child's interest? ________________________
____

Is your child's play easily distracted by:
___ Visual stimuli (e.g. other toys, objects)
___ Auditory stimuli (e.g. voices, sounds outside, TV)
___ Nearby activities
___ Other people in the room
Whom does your child prefer to play with? (circle any that apply)

Mother Father Brother/Sister Self Other child Other adult

List some of your child's favorite toys, TV programs, and videos: __________________
____
____

EDUCATIONAL HISTORY

Educational Setting	Location/School	Teacher(s)
Child Care Facility		
Early Childhood Classes		
Birth to 3 Program (Infants &		

Toddlers)		

Age entered: ______ Any grades repeated? _______

How often does/did your child attend classes?
__Daily __4 x per week __3 x per week
__2 x per week __1/2 days __Full days

How many children are in your child's class? ____________________________________
Child's attitude toward school: ____
Any learning or social problems? ____
Greatest academic interest: ____
Least academic interest: ____

Child's Strengths:

Weaknesses:

What type of classroom is your child in? (e.g. Traditional, open classroom, transdisciplinary, etc.)
____
____

Does your child exhibit any learning style preferences? __Visual __Auditory __Both

Does your child's developmental performance seem to interfere with his/her school performance?
__Yes __No
If yes, please explain: ____
____

Have teachers expressed any concerns about your child's learning behavior? __Yes__No
If yes, please explain: ____
____

Current hours/week of therapy: (school) Speech ___ Occupational ____ Physical ____
Psychology ____ Educational ____ Other:________ hrs ___
Current hours/week of therapy: (private) Speech ___ Occupational ____Physical ____
Psychology ____ Educational ____ Other:________ hrs __
Has your child ever been evaluated for or attended therapy for:

Type of service	Previously	Currently
Speech-Language Therapy (speech, language, feeding, or hearing)		
Audiology (hearing, balance)		
Occupational Therapy		
Physical Therapy		
Psychological or Behavioral Counseling		

Nutritional Services		
Vision Therapy		
Other (describe)		

Please list dates, locations, therapists, and results: _______________________________
____
____

Please list any other information that has not been asked in the above questions: _______
____
____
____
____
____
____
____

Please return a copy of your child's ***current IEP or IFSP*** with this case history. Thank you.