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TAURAI speech & language

Speech Assessment Case History Form

Date D D M M Y Y Y Y

*Please complete this form in **BLOCK CAPITALS** in black or blue ink. Tick where applicable*

Please Note: *This form must only be completed by somebody who has parental responsibility for the child. Before completing this form, the application should be discussed with all those who have parental responsibility for the child.*

(SECTION 1) CHILD INFORMATION

Child's First Name:	Date of Birth: D D / M M / Y Y Y Y	
Child's Last Name:	Initials:	Age:
Child's Gender: Male ☐ Female ☐	Race/Ethnicity: Black/Colored/White/Indian/Other (specify)	

PARENT/GUARDIAN DETAILS

Guardian's Full Name:	Title: Mr./Mrs./Other
Identification Type: ID/Passport/Driver's License	Identification Number:
Relationship to child:	
Home Address:	City:
Home Telephone No.	Work Telephone No.
Preferred email address(es):	
Occupation:	
Referred by:	
Doctor's name:	Doctor's Contact:

(SECTION 2) FAMILY HISTORY

Child lives with: Birth parents ☐ Adoptive parents ☐ Single parent ☐ Parent & step parent ☐ Foster ☐

Other ☐ Specify:

Siblings: Full name	Age

Do any close family members have a history of the following?:		
Speech/Language disabilities:	YES ☐	NO ☐
Learning disabilities (i.e. Dyslexia):	YES ☐	NO ☐
Hearing impairment/deafness:	YES ☐	NO ☐

If you ticked 'YES' to any of the above, please explain the condition(s) further:

Is any language except English spoken in the home: YES ☐ NO ☐

If yes, which language?:	Does the child speak this language?
Does the child understand this language?	
Which language does the child prefer to speak at home?	
Why is this speech evaluation being requested?	

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(SECTION 3) BIRTH HISTORY

Was the child born premature? Yes ☐ No ☐ If yes, at how many years was the child born?:

Was the child healthy at birth Yes ☐ No ☐ If not, kindly explain the condition:

Was there anything unusual about the pregnancy or delivery? Yes ☐ No ☐

If yes, kindly explain the condition:

(SECTION 4) MEDICAL HISTORY

Check/Tick all that apply:

- ☐ Tonsils
- ☐ Snoring
- ☐ Adenoidectomy
- ☐ Difficulty sleeping
- ☐ Ear (PE) tubes
- ☐ Frequent colds
- ☐ Seasonal Allergies
- ☐ Nasal congestion
- ☐ Chronic ear infections
- ☐ Wears glasses
- ☐ Vision problems
- ☐ Tonsillectomy
- ☐ Head Injuries
- ☐ Breathing difficulties
- ☐

Hearing loss diagnosis:

Other medical/genetic issues:

Additional medical information (surgeries, hospitalizations, medications, etc.):

Date of last hearing screening:

Location:

Results: Pass ☐ Fail ☐

Date of last vision screening:

Location

Results: Pass ☐ Fail ☐

(SECTION 5) FEEDING/EATING HISTORY

Check/Tick all that apply:

- ☐ Messy eater
- ☐ Weight issues
- ☐ Limited diet
- ☐ Tongue thrust
- ☐ Sensitive gag reflex
- ☐ Thumb/finger sucking
- ☐ Difficulty nursing
- ☐ Food texture sensitivity
- ☐ Drooling observed
- ☐ Chocking/coughing while eating
- ☐ Food allergies
- ☐ Picky eater
- ☐ Reflux/colic
- ☐ Tongue/lip tie

If you checked any of the above, please explain:

Was the child: Bottle-fed ☐ Breast-fed ☐ For how long?

Does your child primarily breathe through their: Nose ☐ Mouth ☐ Unsure ☐

(SECTION 6) DEVELOPMENTAL HISTORY

Indicate the approximate age at which your child reached the following milestones

Sat alone ..... Walked..... Grasped crayon/pencil .....

Crawled ..... Toilet trained ..... Began to scribble/draw .....

Check all that apply: ☐ Usually active/fidgety ☐ Low muscle tone ☐ Clumsy

☐ Overly sensitive to sound ☐ Easily overwhelmed ☐ Overly sensitive to touch

If you checked any of the above, please explain:

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Has your child been diagnosed with a developmental disability or behavioral disorder? Yes ☐ No ☐
If yes, please specify

(SECTION 7) EDUCATIONAL/ACADEMIC HISTORY
Does your child attend school? Yes ☐ No ☐
If yes, please specify: (i). Child's school:
Does your child have an active IFSP or IEP? Yes ☐ No ☐
If yes, what service(s) does he\she receive?

(SECTION 8) SPEECH AND LANGUAGE DEVELOPMENT
Indicate the approximate age at which your child reached the following milestones
a) Babbled -
b) Put two words together -
c) Said first words -
d) Spoke in short sentences -
Indicate 'Yes', 'No 'or 'Unsure' to the below.
Was your child a quiet infant (limited vocalizations/babbling)?:
Did anything concern you about your child's speech development?:
If yes or unsure, please explain:
Does your child prefer to communicate with: gestures ☐ words ☐ both ☐ neither ☐
Indicate YES, NO or UNSURE
Does your child do the following?
Follow simple directions? Yes ☐ No ☐
Follow complex or multiple-step directions? Yes ☐ No ☐
Ask questions? Yes ☐ No ☐
Understand what you're saying? Yes ☐ No ☐
Identify objections and actions easily? Yes ☐ No ☐

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Respond to yes/no questions easily?
Is your child's speech easily understood by most people ? .....
Respond to yes/no questions easily? .....
If you checked 'No' for any of the above, please explain
Is your child aware of or frustrated by any speech difficulties? Yes ☐ No ☐
If yes, please explain:
What are your specific concerns regarding your child's speech
Please provide some examples of a typical sentence or utterance your child says:

Parental/Guardian Consent

On this day _____ **I** _____

consent for _____ **to have a speech and language evaluation at Taurai.**

Signature _____