Lambert Speech & Language Services
17 Main Street ~ Suite 2 ~ P.O. Box 273
Belchertown, MA 01007
413-218-8526~ Fax 413-323-8443
www.lambertspeech.com ~ info@lambertspeech.com

CASE HISTORY QUESTIONNAIRE

Background Information

Email: ______________________________

Child's Name: ____ D.O.B.: ____________________

Parents' Name(s): __________________________________ Telephone #: ____________________

Address: ______________________________________ Cell # ________________________

City: __________________________ State: ______ Zip: ________ Work #: ________________

Primary language spoken in the home: ____

Who resides in the home with child?____

Pediatrician: _____________________________ Address: ________________________________

City: ______________________ State: _______ Zip: ________ Telephone#: ___________________

Referred by: _________________________________ Profession: __________________________

Address: ____ Telephone#: ____________________

City: _____________________ State: ______ Zip: _______ Reason for referral: _________________

____

____

Has the child's hearing been evaluated? Yes No When: _______________ Where: __________________

Results of hearing evaluation: ____

Has the child been evaluated by the school system? Yes No When: ______________ Results: ____________

____

School/day care name: _________________________ Type of classroom: ________________________

Current school/day care schedule (days/hours child attends): ______________________________________

Name of school/day care contact: _____________________________ Telephone #: _________________

What other services or therapies has your child received?

Dates:	Type of Therapy	Frequency of Therapy	Professional's Name	Location

Prenatal History (circle your responses where indicated)

Did the mother have any infections/illnesses/injuries during pregnancy? Yes No Describe: _______________

____

Were any medications taken during pregnancy? Yes No Describe: _________________________________

____

Were there any indications that the baby was not doing well? Yes No Describe: ______________________

____

CASE HISTORY QUESTIONNAIRE (Page 2)

Birth History (circle your responses where indicated)

Were there any complications during delivery or labor? Yes No Describe: ______________________________________

____

Delivery was: Vaginal C- Section: Planned or Emergency Describe: ________________________________

____

Child was: Full Term Premature: # of weeks early _____________ Birth weight: ________lbs.; _________ oz.

Child presented: Head First Breech APGAR Scores: ____

Was child jaundiced? Yes No Type of treatment provided: ____

Did the child require intensive hospitalization or special medical attention after birth? Yes No Describe: ___________

____

Were there any birth defects or medical conditions noted after delivery? Yes No Describe: ______________________

____

Medical History (circle your responses where indicated)

Are immunizations current? Yes No Height: __________ Weight: _________ Head Circumference: ____________

Medical diagnosis (if any): ____

Medical precautions: ____

List any surgeries, illnesses or hospitalizations (include dates): ____

____

Does / has the child had: Seizures Frequent ear infections Allergies Other: ________________________

____

Please list current medications: ____

____

Does **anyone** else in the family have speech, language or learning difficulties? Yes No Describe: ____________

____

Do you have concerns about the child's nutrition? Yes No Describe: ____

____

Developmental History (circle your responses where indicated)

Did / does the child have feeding problems? Yes No Describe: ____

____

Was child breast fed? Yes No Difficulty latching on to breast or nursing? Yes No Describe:___________________

____

Did / does the child refused certain food textures, tastes, temperatures? Yes No Describe: _______________________

____

Did the child have difficulty transitioning from breast / bottle to solids (i.e. purees, soft solids, solids)? Yes No

Describe: ____

Did / does the child have colic? Yes No Describe: ____

Does the child have behavior problems? Yes No Describe: ____

CASE HISTORY QUESTIONNAIRE (Page 3)

Developmental Milestones: (Give approximate **ages**; comment as warranted)

Motor	Speech & Feeding
Rolled over ______	Vocalized sounds______
Sat unsupported ______	Babbled ______
Crawled ______	First word emerged (age) ______
Pulled to stand ______	Two word phrases ______
Walked ______	Started on soft solids ______
Removed clothes ______	Started on solids ______
Dressed Self ______	Fed self ______
Completed fasteners ______	Used pacifier? Yes No Ages used ______
Tied shoes ______	Suck thumb or fingers? Yes No Until age ______

Rate the child's speech on a scale of one to five (*One being that the child's speech is not understood at all by others and five that speech is always understood by others*): 1 2 3 4 5

Does the child understand when he/she is spoken to: Yes No ______

Does he/she follow directions? Yes No ______

Does he/she point to objects or pictures when asked? Yes No ______

Primary means of communication: (circle all that apply): Speech Sign Language Gestures / Pointing Pictures Screaming Grunting Combination Other: ______

Does he/she use a lot of different words? Yes No ______

How many words does he/she put together to make a sentence? 1 2 3 4 5 6 or more

Does the child have an increased activity level or distractibility? Yes No Describe: ______

______

Does the child have difficulty handling small objects or with handwriting? Yes No Describe: ______

______

Does the child seem over or under- active to certain types of sensory input (touch, sound, movement, smells)? Yes No

Describe: ______

Does the child have difficulty with gross motor coordination (i.e. walking,, running jumping, climbing)? Yes No

Describe: ______

What are the child's favorite activities? ______

______

Comments: ______

______

______

______

Thank you for taking the time to complete the questionnaire. We are looking forward to meeting you and your child.

Parent/Guardian's Signature: ______ Date: ______

Clinician's Signature: ______ Date: ______