Please check one:
Diagnostic:_____
Intervention:_____

Cobblestone Speech, Language and Learning LLC

10789 Bradford Road, Suite 202
Littleton, CO 80127
303-952-9038 ◆ Fax 720-389-7067

PLEASE ATTACH ANY REPORTS FROM PREVIOUS AGENCY OR SCHOOLS

Child Case History

PLEASE PRINT IN INK OR TYPE ALL INFORMATION

General Information

Today's Date _____

Child's Name _____ Date of Birth: _____ Gender ____

Address: _____ Phone: _____

City:_____ Zip: _____

Mother's Name: _____ Age:_____

Mother's Occupation: _____ Business Phone: _____

Father's Name: _____ Age:_____

Father's Occupation:_____ Business Phone: _____

Does the child live with both parents? _____

If no, with whom does the child live?_____

Brothers and Sisters (include names and ages): _____

Referred By: _____ Phone: _____

Address: _____

Physician: _____ Phone: _____

Address: _____

Office Use Only:

Other specialists who have seen the child: _____

Please attach the most recent report for the Doctor, agency or school listed above.

Address: _____ Phone: _____

What were the other specialists' conclusions and/or recommendations?_____

_____

_____

What language (s) does the child speak? _____

How does the child usually communicate?

Gestures Sign Language Single Words Short Phrases Sentences

Describe the child's speech-language or hearing problem._____

_____

_____

When was the problem first noticed? _____

Who first noticed the problem? _____

What do you think may have caused the problem?_____

_____

_____

Since you first noticed the problem, what changes have you observed in your child's speech, language, or hearing?_____

_____

_____

_____

_____

Is the child aware of the problem? _____

_____

_____

What have you done to help your child with the problem? _____

_____

_____

Describe other speech, language, or hearing problems in the family._____

_____

_____

Prenatal and Birth History

Describe mother's general health during pregnancy (illnesses, accidents, prescription and non-prescription medications, etc.). _____

_____

Length of pregnancy: _____ Length of labor: _____

Child's general condition:_____ Birth weight: _____

Circle type of delivery: head first feet first breech Cesarean

Were forceps used? _____

Child's length of stay in hospital: _____

Describe any unusual conditions that may have affected the pregnancy or birth. _____

_____

Medical History

Child's general health is: Good Fair Poor

Provide the approximate ages at which the child experienced the following illnesses and conditions.

Adenoidectomy _____	Asthma _____	Allergies _____
Chicken pox _____	Colds_____	Convulsions _____
Croup_____	Draining ear _____	Dizziness _____
Ear infections _____	Epilepsy _____	Encephalitis _____
German measles _____	Headaches_____	Hearing loss _____
Heart problems _____	High fever_____	Influenza_____
Measles _____	Mastoiditis _____	Meningitis_____
Mumps _____	Noise Exposure_____	Pneumonia _____
Seizures_____	Sinusitis _____	Tinnitus_____
Tonsillitis _____	Tonsillectomy_____	Visual Problems _____
Other _____	Glasses _____	

List child's current medications._____

_____

Describe any major accidents, surgeries, or hospitalizations the child has had._____

_____

_____

_____

Developmental History

Write the approximate age when the child began to do the following.

Crawl_____ Sit _____ Stand _____ Walk_____ Feed Self _____

Dress Self _____ Use toilet _____ Use single words _____ Combine words _____

Name simple objects_____ Use simple questions _____ Engage in a conversation _____

Does the child have any motor difficulty, such as walking, running, or participating in other activities which require small or large muscle coordination? _____

_____

_____

Describe any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.) your child has had. _____

_____

_____

Does the child:

Respond to any sounds? _____

Respond to the sound of the telephone bell? _____

Respond to the sound of human voices?_____

Respond to loud sounds only? _____

Respond to sounds inconsistently? _____

Seem to ignore sounds willfully? _____

Do you suspect any problems with hearing? _____

General Behavior

Does the child eat well? _____ Sleep well? _____

How does the child interact with other family members? _____

_____

Is the child: attentive _____ extremely active _____ restless_____

Does the child bang his/her head, rock, or spin? _____

Does the child play by him/herself? _____

How does the child interact with other children? _____

Does the child lose his/her temper? _____

With whom does the child spend most of the day? _____

Educational History

School or Preschool: _____ Grade: _____

Teacher (s): _____

Describe any special services your child receives. _____

_____

If enrolled for special education services, list main goals of the Individualized Educational Plan (IEP) or

Individual Family Service Plan (IFSP). _____

_____

_____

Please add any additional information you feel might be helpful in the evaluation or treatment of the child's problem. _____

_____

_____

_____

Person completing the form: _____

Relationship to the child: _____

Signed: _____ Date: _____

PLEASE ATTACH ANY REPORT YOU HAVE FROM ANOTHER AGENCY, SCHOOL OR DOCTOR.