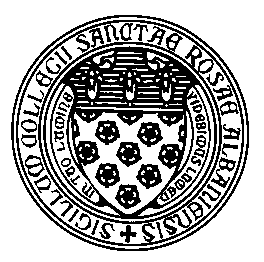
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**The Pauline K. Winkler Speech-Language-Hearing Center**

at

The College of Saint Rose

432 Western Avenue

Albany, NY 12203

(518) 337-4914 / Fax: (518) 337-2313

Director of Clinical Services, Melissa Spring, M.S., CCC-SLP

Coordinator of the Winkler Center, Grace Paster, M.A., CCC-SLP

Coordinator of Early Intervention & Preschool Services

**Case History Form**

Child’s Name:       Date of Birth:        Male  Female

Parent/Guardian:       Age:       Occupation:

Address:       Phone:

Parent/Guardian:       Age:       Occupation:

Address:       Phone:

Physician’s Name:

Physician’s Phone Number:       Ext:

Referred By:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Others Living with Child | Relationship to Child | Age | Gender |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Has your child ever received Early Intervention/CPSE or speech therapy services through The Winkler Center?  Yes Date:        No

Is there a language(s) other than English spoken at home?  Yes  No

If yes, what language(s)?

Does your child speak a language other than English? Yes No

If yes, what language(s)?

What is your child’s primary language?

With whom does your child spend most of his/her time?

Why are you seeking this evaluation?

What is your primary concern?

In what ways does your family assist your child to communicate more effectively? What have you done that has been successful?

Is your child aware of his/her speech and/or language difficulty?  Yes  No

If yes, how does he/she feel about it?

Have any family members had any speech, language, hearing problems, or learning difficulties?

Yes  No If yes, who?

Please describe:

**Pregnancy and Birth History:**

|  |  |  |  |
| --- | --- | --- | --- |
| Illness / Hospitalization/  Surgery During Pregnancy | Date of Procedure | Reason | Length of Stay |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Length of gestation:       Delivery: Vaginal  Cesarean

If cesarean delivery, what was the reason?

Was the cord around your child’s neck?  Yes  No

Were there any breathing problems?  Yes  No

Did he/she require any transfusions?  Yes  No

Did he/she require the use of phototherapy?  Yes  No

Other:

Was there drug, alcohol, and/or medication use before or during pregnancy?  Yes  No

If yes, what was used and how often?

Did your child’s mother go home before him/her?  Yes  No Reason:

How long did your child stay in the NICU?

**Medical Information:**

Does your child have any medically diagnosed illnesses or conditions?  Yes  No

If yes, what?

Please list medications currently being taken by your child:

|  |  |  |
| --- | --- | --- |
| Medication | Purpose | Dose |
|  |  |  |
|  |  |  |
|  |  |  |

Have there ever been any negative reactions to medications?  Yes  No

If yes, please describe:

Describe any surgeries, accidents, or hospitalizations:

Please provide approximate ages at which your child had the following illnesses or conditions:

|  |  |  |
| --- | --- | --- |
| Allergies: | Asthma: | Chicken Pox: |
| Colds: | Convulsions: | Croup: |
| Dizziness: | Draining Ear: | Ear Infections: |
| Encephalitis: | German Measles: | Headaches: |
| High Fever: | Influenza: | Mastoiditis: |
| Measles: | Meningitis: | Mumps: |
| Pneumonia: | Seizures: | Sinusitis: |
| Tinnitus: | Tonsillitis: | Lyme Disease: |
| Other: | | |

**Developmental Information:**

Please describe the approximate age at which your child began to do the following:

|  |  |
| --- | --- |
| Roll Over: | Crawl: |
| Sit: | Stand: |
| Walk: | Feed Self: |
| Dress Self: | Use Toilet: |
| Use Single Words: | Combine Words: |

Compared to his/her peers, does your child have difficulty with any of the following activities that require small or large muscle coordination? Please circle all that apply.

Running Walking Grasping crayons or pencils Other:

Have there ever been any difficulties with eating? Please circle all that apply.

Sucking Swallowing Drooling Chewing

Other:

**Educational History:**

What school is your child currently attending?       What grade is your child in?

Teachers:

Please describe your child’s current academic or pre-academic strengths:

Please describe any concerns you may have regarding your child’s current academic or pre-academic abilities:

Does your child receive special services?  Yes  No

If yes, please describe:

Does your child currently have an IEP, IFSP, or 504 Plan?  Yes  No

How does your child interact with other children? Please check all that apply.

Friendly  Cooperative  Outgoing  Shy Aggressive

Other:

**Speech and Language:**

How does your child currently communicate? Please check all that apply.

Gestures  Single-words Short Phrases  Sentences

Describe your child’s reaction to sounds. Please check all that apply.

does not respond inconsistently responds  responds to loud sounds only

responds to all sounds Is uncomfortable with loud sounds

How well does your child appear to understand spoken language?

Less than 10% 25%  50%  90-100%

Approximately how much of your child’s speech do you understand?

Less than 10%  25%  50% 75%  90-100%

**Please complete the following section if your child is *under* 5-years-old.**

How many words does your child typically use in a sentence?

Please provide an example of your child’s speech:

Does your child:

Identify objects?  Yes  No

Ask questions?  Yes  No

Follow directions?  Yes  No

Respond correctly to yes/no questions?  Yes  No

Respond correctly to “wh” (i.e., who, what, etc.) questions?  Yes  No

**Additional Information:**

Please provide any additional information that might be helpful to us in understanding and helping your child (i.e., teacher observations, progress notes, etc.).

What would you like to see happen in the future for your child?

Person completing this form:

Relationship to child:

Date: