Speech Therapy Telepractice and Technology

Graduate Student Training Program
Department of Communication Sciences and Disorders

Child Case History Form

Confidentiality Statement

In order to provide the optimum level of service, appropriate to your child's needs and wishes, certain background information is very helpful. The information requested will assist us in understanding and developing a plan that best suits your child's needs. Many factors may impact on the hearing, understanding, and use of speech. The information you provide us will help us understand your concerns and assist us in addressing your needs.

If possible, complete this information form on behalf of your child and return it to us a week before the date of the first appointment. Thank you for your time and cooperation.

General Information

Name of Client: ______________________ Date of Birth: ______________

Address: ______________________ Phone: ______________

City: ______________________ Zip: ______________

Email Address: ______________________

School: ______________________

Parent's Marital Status: Single ____ Widowed/Divorced ____ Married ____ Spouse's Name: ______________

Siblings (include name, gender and ages): ______________________

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Name of person completing questionnaire if other than the client named above: ______________

Referred by: ______________________ Phone: ______________

Address: ______________________

Primary Care Physician: ______________________ Phone: ______________

Address: ______________________

Person/Agency paying for service: ______________________

Medical History

Describe the events that led to your child's current speech and language problems.

Status of vision and hearing:____

Condition of oral structures (i.e., teeth, tongue, etc.): ______________________________________

Oral/motor impairments (i.e., slurred speech, weakness of lips, tongue, jaw, etc.): ______________________________

____

Special concerns regarding physical condition: ____

____

Describe any major surgeries, operations or hospitalizations that you have experienced in the past (include approximate dates).

Check which of the following illnesses and conditions you have experienced:

Adenoidectomy	________	Allergies	_______	Asthma	________	Chicken Pox	__________
Convulsions	________	Dizziness	_______	Draining Ear	________	Ear Infections	__________
Encephalitis	________	German Measles	_______	Headaches	________	Hearing Loss	__________
High Fever	________	Influenza	_______	Mastoiditis	________	Noise Exposure	__________
Otosclerosis	________	Pneumonia	_______	Seizures	________	Sinusitis	__________
Tinnitus	________	Stroke	_______	Tonsillectomy	________	Head Injury	__________

Other: ____

Does your child have any eating or swallowing difficulties? If so, please describe.

List all medications your child is currently taking.

Is your child having any negative reactions to these medications? If yes, please describe.

Describe any cognitive and/or language difficulties your child is currently experiencing.

What do you believe may have caused these difficulties?

How does your child's communication difficulty affect his/her school work, daily activities at home, with friends, in the community, etc.?

Developmental and Educational History

What grade is your child in school? ________

Did your child reach developmental milestones on time? If no, please describe.

Does your child have a history of learning disability, reading or writing problems? If yes, please describe.

Describe any problems your child is experiencing in school.

Family History

Describe your family members and where they live.

Are there any family members who experience communication difficulties? If yes, tell us your child's relation to the family member and describe the nature of the difficulties.

What languages are spoken at home? Include the languages your child speaks and indicate which is the primary language.

Hobbies and Interests

What are your child's hobbies and/or special interests?

What activities does your child participate in (church, community, etc.)?

Computer Skills

1. Describe your child's knowledge of computers and any other digital devices that your child knows how to operate.

2. Does your computer have video and audio connections? Yes No

3. Do you have Internet access? Yes No

4. How many years has your child used computers? ______________________

5. How often does your child use computers, smart phones or other digital devices?

Daily Weekly Monthly

6. Rate your child's knowledge and experience of using computers.

Beginner Average Advanced

Why did you decide to request speech therapy telepractice services? What do you hope will result?

Provide any additional information that might be helpful in the evaluation or therapy process.

Person completing this form: ____

Signature: ____ Date: ______________

If you have any questions regarding the completion of this information form, call our office at 207.581.2006.

Return this form to:

lynk@maine.edu

or

Madelyn E. and Albert D. Conley Speech, Language and Hearing Center
Department of Communication Sciences and Disorders
University of Maine
5724 Dunn Hall, Room 344
Orono, ME 04469-5724