magnolia speech school
733 Flag Chapel Road
Jackson, MS 39209
601.922.5530

SPEECH AND LANGUAGE CASE HISTORY FORM

GENERAL INFORMATION:

Please attach a recent photo of your child here

Child's Name: _____
Date of Birth: _____ Age: _____

Home Address: _____
_____
City: _____
State: _____ Zip: _____
Home Phone: _____

Mother's Name: _____ Age: _____ Email: _____
Occupation: _____ Mother's Education: _____
Work Phone: _____ Cell: _____

Father's Name: _____ Age: ____ Email: _____
Occupation: _____ Father's Education: _____
Work Phone: _____ Cell: _____

Is English the primary language spoken in the home? (__) yes (__) no
If no, what language? _____

Does your child live with both parents? (__) yes (__) no
If no, please indicate with whom the child lives: _____

List any other children living in the home:

Name	Sex	Age	School/Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who referred you for this evaluation? _____

How did you find out about Magnolia Speech School? _____
What is the purpose of this evaluation? _____

BIRTH HISTORY:

- Check which is applicable: This is our (__) biological child (__) foster child (__) adopted child.
- Mother's age at birth: _____ Number of pregnancies: _____
- When did the mother begin prenatal care? _____
- Where did the mother receive prenatal care? _____
- Physician's name: _____
- List any illnesses during pregnancy: _____
- List any medications taken during pregnancy: _____
- Did the mother do any of the following activities while pregnant?
  (__) drink alcohol (__) smoke cigarettes (__) use recreational drugs (i.e., marijuana, cocaine)
- Type of delivery: (__) vaginal (__) caesarean section
- What week of gestation was the baby delivered? _____ weeks
- Child's birth weight: ____ pounds, ____ ounces Child's length at birth: ____ inches
- Baby's color at birth: (__) normal (__) blue (__) yellow (__) other: _____
- Did the infant require a stay in the neonatal intensive care unit (NICU)? (__) yes (__) no
  If yes, please explain: _____
- Any injuries or deformities at birth? (__) yes (__) no
  If yes, please explain: _____
- Did your child pass his/her newborn hearing screening? (__) yes (__) no
  If no, please list further testing: _____
- Describe your child's health during the first weeks of life: _____
  _____

Please check any complications experienced during pregnancy:

(__) high blood pressure	(__) weight loss	(__) excessive weight gain
(__) frequent sonograms	(__) fever	(__) excessive bleeding
(__) toxemia	(__) kidney problems	(__) infections
(__) excessive vomiting	(__) diabetes	(__) other: _____

DEVELOPMENTAL INFORMATION:

- Does your child exhibit any gross motor problems? (__) yes (__) no
  (__) walking (__) hopping (__) running (__) other: _____
- Does your child exhibit any fine motor problems? (__) yes (__) no
  (__) stacking blocks (__) buttoning (__) cutting (__) zipping (__) other: _____

Please indicate the age in months your child did each of the following:

_____ sat alone	_____ crawled	_____ stood alone
_____ walked alone	_____ drank from a cup	_____ used spoon
_____ toilet trained bladder	_____ toilet trained bowel	

What does your child enjoy playing with or doing in his/her free time? _____

_____

SPEECH/LANGUAGE:

- Please indicate the age in months when your child did each of the following:
  _____ babbled (i.e., *bububu, mamama, dadada*)
  _____ used single words (i.e., *mama, no, doggie)*
  _____ combined words (i.e., *me go, daddy shoe*)
- Please indicate if your child has a family history of the following problems:
  (__) hearing (__) speech (__) learning (__) language (__) reading
  If so, please explain: _____
  _____
- Did speech learning ever seem to stop or regress for any period of time? (__) yes (__) no
  If yes, please explain: _____
  _____
  _____
- Does your child seem to understand what is said to him/her? (__) yes (__) no
  If so, how does he/she indicate this to you? _____
  _____

- My child is: (__) verbal (__) nonverbal
- Does your child prefer to use? (__) speech (__) gestures (__) both
- How does your child communicate needs? (__) speech (__) gestures (__) both

- If your child is verbal, he/she speaks using:
  (__) single words (__) single words approximations (i.e., cu for cup)
  (__) 2-3 word phrases (__) sentences

- How often do family members understand your child's speech?
  (__) never (__) sometimes (__) most of the time (__) always
- How often do others understand your child's speech?
  (__) never (__) sometimes (__) most of the time (__) always
- How often does your child use speech?
  (__) never (__) sometimes (__) most of the time (__) always

- Does your child make any sounds incorrectly? (__) yes (__) no
  If yes, please explain: _____
  _____
  _____
- How would you describe your child's speech/language problem(s)? _____
  _____
  _____
  When was this first noticed? _____ By whom? _____

- What is your child's attitude towards this problem (e.g. frustrated, angry, indifferent, etc.)?
  _____

MEDICAL INFORMATION:

- Name of your child's physician: _____
- Please indicate if your child has been given a formal diagnosis such as: autism, cerebral palsy, developmental delay, genetic syndrome, etc.: _____
  _____
  When was it made? _____ By whom? _____
- Are your child's immunizations up to date? (__) yes (__) no
- Is your child taking any medication? (__) yes (__) no
  If so, what medications? _____
  _____
  For what reason? _____

IF YOUR CHILD TAKES PRESCRIPTION MEDICATION FOR ADD OR ADHD, PLEASE HAVE HIM/HER TAKE THE MEDICATION AS PRESCRIBED ON THE DAY OF THE EVALUATION.

- Has your child ever had surgery or been hospitalized? (__) yes (__) no
  If yes, please indicate why: _____
  _____
  When did this occur? _____

Please check any of the following your child has had:

(__) hay fever	(__) pneumonia	(__) hepatitis	(__) mononucleosis
(__) asthma	(__) bronchitis	(__) very high fever	(__) sinus infection
(__) tonsillitis	(__) meningitis	(__) seizures	(__) mumps
(__) skull fracture	(__) hyperbilirubinemia	(__) encephalitis	(__) chicken pox
(__) diphtheria	(__) frequent colds	(__) measles	(__) head injury/accident
(__) seasonal allergies			

ALLERGIES:

- Please list anything your child is allergic to, including any food and/or environmental allergies.
  _____
  _____
  Does your child have an Epi Pen? (__) yes (__) no

VISION:

- Does your child's vision seem normal? (__) yes (__) no
- Is your child color blind? (__) yes (__) no
- Has your child had a visual exam? (__) yes (__) no
  If so, results: _____
- Does your child wear eyeglasses? (__) yes (__) no
  IF YOUR CHILD WEARS EYEGLASSES, PLEASE BRING THEM TO THE EVALUATION.

HEARING:

- Does your child have tubes? (__) yes (__) no

If yes, which ear(s)? (__) Left (__) Right Still in Place? (__) yes (__) no
When was the procedure done? _____ By Whom? _____

- Does your child have a history of middle ear infection? (__) yes (__) no
- When was the most recent ear infection? _____
- Please check all that apply:
  (__) four or more ear infections in one year (__) ear problem in the last six months
  (__) ear infection before the age of one (__) ear problem lasting three months or longer
  (__) draining ear

- Do you think your child has a hearing loss? (__) yes (__) no
- Has your child ever had a hearing evaluation? (__) yes (__) no
  If so, when? _____ Where? _____
  Results: _____

- Does your child wear hearing aids? (__) yes (__) no
  If yes, which ear(s)? (__) Left (__) Right

- Does your child have a cochlear implant? (__) yes (__) no
  If yes, when was he/she implanted? _____
  Where? _____ By whom? _____

***IF YOUR CHILD WEARS AIDS OR AN IMPLANT,*
*THEY MUST WEAR THEIR DEVICE DURING THE EVALUATION.***

COGNITIVE AND SOCIAL:

- Can your child tell you his/her name? (__) yes (__) no
- Can your child tell you his/her age? (__) yes (__) no
- Compared to other children of your child's age, does he/she:

Look at books independently:	(__) yes	(__) no
Count to three:	(__) yes	(__) no
Count to ten:	(__) yes	(__) no
Point to colors named:	(__) yes	(__) no
Follow simple directions:	(__) yes	(__) no
Get along with siblings:	(__) yes	(__) no
Get along with other children:	(__) yes	(__) no
Make friends easily:	(__) yes	(__) no
Play with age appropriate toys:	(__) yes	(__) no
Enjoy being read to:	(__) yes	(__) no
Enjoy playing alone:	(__) yes	(__) no
Enjoy playing with other children:	(__) yes	(__) no
Easily adapt to change:	(__) yes	(__) no
Appear overactive:	(__) yes	(__) no
Appear overanxious:	(__) yes	(__) no

FEEDING:

- Does your child have difficulty with chewing/swallowing? (__) yes (__) no
  If so, please indicate the food consistency that causes problems:
  (___) crunchy (___) chewy (___) soft (___) other: _____

- Does he/she avoid any foods or consistencies? (__) yes (__) no
  If so, please list: _____
- Does he/she mouth objects (pencils, hands, etc.)? (__) yes (__) no
  If so, please list: _____
- Does he/she gag easily with food or utensils in mouth? (__) yes (__) no

THERAPY INFORMATION:

- Is your child followed by First Steps? (__) yes (__) no
  If yes, who is your First Steps Service Coordinator? _____

- Has there been a previous evaluation? (__) yes (__) no
  When? _____ Where? _____
  Results: _____
  Recommendations: _____

- Is your child currently receiving treatment for this problem? (__) yes (__) no
  If yes, where? _____
- Please describe any speech/language, hearing, OT, PT, psychological/behavioral, special education services, or tutoring that your child is receiving/has received. _____
  _____
  _____

Type of Therapy *(ex, ST, OT, PT, ABA)*	**Therapist Name**	**Frequency** *(ex, two 30 minute sessions/week)*	**Place** *(ex, school, Beyond Therapy)*	**Group or Individual Therapy**	**Duration** *(ex, 01/16 to 09/16)*

PLEASE BRING ANY REPORTS WITH YOU OR USE THE ATTACHED FORM (Request for copies of Records) TO HAVE REPORTS SENT TO US.

Has your child been seen by any other professionals for any reason other than routine care?
(__) yes (__) no If yes, by whom? _____
Reason: _____
_____

EDUCATIONAL INFORMATION: *(Please fill out if your child is enrolled in school/daycare.)*

- Name of School: _____ Grade: _____
- Teacher's Name: _____
- Does your child have any problems with peers, teachers, or learning activities?
  If so, please explain: _____
  _____
- Has your child been evaluated by your public school? (__) yes (__) no
  If so, what were the results? _____
  _____
  _____
- Does your child have an eligibility ruling? (__) yes (__) no
  If so, what is the ruling? _____
- Does your child attend a special education class? (__) yes (__) no
  If so, what type of class? _____
- If your child did not attend daycare of nursery school, who took care of him/her during the day?
  _____
- Has your child ever had special tutoring or any type of therapy? (__) yes (__) no
  If so, when? _____
  Where? _____ Whom? _____

- Has your child ever repeated a grade? _____ If yes, what grade(s)? _____
  What were the reasons why your child repeated the grade(s)? _____
  _____

- Please describe any behavioral problems your child has:
  _____
  _____
  _____

- Information provided by: _____ Date: _____
- Relation to the child: _____

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Consent for Evaluation

Child's Name: _____

I hereby give consent for my child (shown above) to be evaluated/observed by the staff of Magnolia Speech School.

_____ _____
Signature of Parent/Guardian Date

Request for Copies of Records

To: _____

_____

Fax Number: _____

Child's Name: _____
Date of Birth: _____

The above named client is scheduled for testing at Magnolia Speech School. Please send copies of any and all records you may have which would be pertinent to the design of appropriate educational programming to:

Magnolia Speech School
733 Flag Chapel Road
Jackson, MS 39209
Telephone (601) 922-5530 / Fax (601) 922-5534

_____ _____
Signature of Parent/Guardian Date

I, the above signed parent/guardian, hereby give my permission for these records to be photocopied and shared by the agencies named herein.

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Permission To Send Test Results

Please send a copy of this evaluation to the persons/agencies listed below:

Child's Name: _____
Date of Birth: _____
Date of Testing: _____

1. Name: _____
   Address: _____
   _____
2. Name: _____
   Address: _____
   _____

Parent/Guardian Signature: _____

Date: _____