Collier Language and Literacy Therapy
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Case History

Today's Date: _____

Client Name: _____ Nickname if Preferred: _____
Date of Birth: _____ Age: _____ Gender: _____
Address: _____

Questionnaire Completed by: _____ Phone #:_____
Referred By: _____

Parent(s)/Guardian(s):
Name: _____ Name: _____
Phone #: _____ Phone #: _____
Email: _____ Email: _____

Pediatrician Name: _____ Phone #: _____
Address:_____

Please list and describe any other physicians/specialists involved in care:_____
_____
_____

Family Background

Does the child live with both parents? □ Yes □ No

_____

Is the child adopted? □ Yes □ No

_____

Names and ages of any siblings:_____
_____

Are any languages other than English spoken in the home? □ Yes □ No
Describe the child's use/understanding of language(s) other than English: _____
_____

Is there anything additional you would like to share about the family / home environment? _____
_____

Background

Describe the nature of your concerns about the child's development and/or the primary referral reasons: _____
_____
_____
_____

If anyone else in the family has a speech/language disorder, learning disability, or related diagnosis, please describe: _____
_____

Is the child aware of or frustrated by their communication or learning difficulties? _____
_____
_____

Has the child had a previous speech-language, psychological, or other evaluation?
□ Yes □ No
Please list evaluators, dates, and results:_____
_____
_____
_____

What would you like to see done about your child's speech, language, or learning difficulties?_____
_____
_____
_____

What are some of the questions that you would like answered about your child's difficulties? _____
_____
_____

_____

_____

Medical/Developmental History

Were there any complications during pregnancy, labor, or delivery? ☐ Yes ☐ No

Please describe:_____

_____

Did the child reach developmental milestones on time? ☐ Yes ☐ No

Please describe:_____

_____

Does the child have a history of any of the following?

☐ Allergies	☐ Ear infections	☐ Seizures
☐ Asthma	☐ Ear/PE tubes	☐ Sensory issues
☐ Behavior problems	☐ Feeding/Swallowing issues	☐ Sleep problems
☐ Breathing problems	☐ Hearing Loss/Hearing Aids	☐ Tongue/lip tie
☐ Cardiac condition	☐ High fever	☐ Tonsils/adenoids removed
☐ Cleft lip/palate	☐ Hospitalization	☐ Traumatic brain injury
☐ Diabetes	☐ Surgeries	☐ Vision problems

Please describe any checked items: _____

_____

_____

Has the child been diagnosed with any other medical condition? ☐ Yes ☐ No

Please describe: _____

_____

Has the child had a recent hearing screening? ☐ Yes ☐ No

When and by whom? _____

Has the child had a recent vision screening? ☐ Yes ☐ No

When and by whom? _____

Is the child up to date with immunizations?: ☐ Yes ☐ No

Please describe: _____

Does the child currently take any medications? ☐ Yes ☐ No

If so, please list medication name and reason for medication: _____
_____

Describe any other information about the child's current health status: _____
_____
_____
_____

Has the child received any of the following services? If yes, please list the provider's name and last date of service.

☐ Developmental Pediatrician _____
☐ Neurologist _____
☐ Physical Therapist _____
☐ Occupational Therapist _____
☐ Speech-Language Pathologist _____
☐ Behavioral Therapist _____
☐ Psychologist / Psychiatrist _____
☐ Tutor _____
☐ Other: _____

Does the child have any difficulty with the following:

☐ Answering wh- questions
☐ Confusing words that sound alike
☐ Following directions
☐ Hyperactivity
☐ Organization
☐ Producing speech sounds
☐ Memory
☐ Social Skills
☐ Stuttering
☐ Understanding what they hear
☐ Attention
☐ Behavior
☐ Handwriting/fine motor skills
☐ Gross motor coordination
☐ Playing with others
☐ Reading
☐ Rhyming
☐ Spelling
☐ Telling Stories
☐ Word Retrieval
☐ Other difficulties: _____

Please describe any of the above: _____
_____
_____

What percentage of the child's speech do you understand? _____%

How well do people outside of the family understand their speech? _____%

Educational History

What school does the child attend? _____

What is their grade level: _____

Does the student have an IEP? □ Yes □ No

Does the student have a 504 Plan? □ Yes □ No

Does the student have a Behavior Plan? □ Yes □ No

Does the student receive other intervention services? □ Yes □ No

Describe special education/intervention services:_____

_____

_____

Social History

What are the child's strengths? _____

_____

_____

What are the child's weaknesses? _____

_____

_____

What are the child's favorite activities? _____

_____

_____

Does the child participate in any community activities (ex. sports, etc.)? _____

_____

_____

Is there anything else that is important for us to know about the child?

_____

_____

_____

_____

_____

_____