

SPEECH AND LANGUAGE CENTER OF NORTHERN VIRGINIA

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Dolley Madison Preschool
(703) 356-1351

Speech & Language Services
(703) 356-2833

Case History

Child's Name: _____
Last First Middle Nickname

Date of Birth: _____ Chronological Age: _____ Sex: _____

Home Address: _____ Telephone: _____
Other Telephone _____

Father's Name: _____

Place Employed: _____ Work Phone: _____

Mother's Name: _____

Place Employed: _____ Work Phone: _____

Please provide address and phone number if a parent has a different address _____

Person(s) or agency having legal custody of child: _____

Home Address: _____ Home Phone: _____

Business Address: _____ Work Phone: _____

EMERGENCY INFORMATION

Pediatrician: _____ Telephone: _____

Emergency contact (name, address and phone number of two designated people to call in an emergency if a parent cannot be reached) Please remember to include the address. These people are also authorized to pick up my child.

1. _____ Telephone: _____

2. _____ Telephone: _____

Other person(s) authorized to pick up my child: _____

Person(s) not authorized to pick up child, if any: _____

(Appropriate paper work such as a divorce decree shall be attached if a parent is not allowed to pick up the child)

BACKGROUND INFORMATION

I. Birth and Developmental History

a. Was your child adopted? _____ Date _____ From where? _____

b. Pregnancy

Was mother's condition during pregnancy good to excellent? [] yes [] no

If no, please explain: _____

Were medications taken during pregnancy? [] yes [] no

Were there any illnesses or complications during pregnancy? [] yes [] no

Please explain _____

At how many weeks gestation was baby born? _____

What was birth weight? _____

c. Labor and Delivery

Were labor and delivery normal? [] yes [] no If not, please explain: _____

Was labor induced? [] yes [] no If yes, please explain. _____

Was there evidence of injury or poor health at birth? [] yes [] no if yes, please explain: _____

Was the baby of average activity level? [] yes [] no

During the first month of life, was his/her health good? [] yes [] no if no, please explain: _____

d. Infancy and Early Childhood

Were there any feeding problems? [] yes [] no _____

II. Medical History

Diseases child has had: note ages, severity, whether accompanied by high fever, and the effects.

Disease	age	severity & effects	high fever
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List injuries and/or operations	age	severity hospitalization
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Is any medication taken on a regular basis? [] yes [] no if so, what? _____

Was development of teeth normal? _____

List allergies or intolerance to food: _____

Actions to take in the event of an allergic reaction/emergency? _____

Does your child have a history of ear infections? [] yes [] no

Has vision been tested?	When	Results
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Has hearing been tested?	When	Results
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III. Motor Development

1. Please indicate age when the following skills were first performed.

creeping _____ crawling _____ sitting unassisted _____
 walking _____ hopping _____ skipping _____
 using crayon _____ using scissors _____

2. Has the child established handedness? if so, which hand? no yes, right left

3. Indicate age when voluntary bladder control was achieved _____ bowel control _____

IV. Social and Emotional Development

1. If your child exhibits or has exhibited the following behaviors, please indicate age of occurrence and how you have attempted to deal with it.

shyness _____

thumb sucking _____

difficulty separating from parents _____

face twitching _____

strong fears - nightmares _____

temper tantrums _____

sleeplessness _____

nervousness _____

difficulty sitting still _____

inability to stay with one activity until completion _____

negativeness _____

bedwetting _____

2. Does he/she have the opportunity to play with other children his/her age? yes no

3. If so, does he/she play with them? yes no

4. Does he/she play with younger children? yes no

5. Does he/she play with older children? yes no

6. Are you ever concerned because he/she doesn't play well with other children? yes no

7. What are the child's favorite activities? _____

8. Primary type of discipline: spanking isolation (time out) verbal reasoning other _____

9. Do you feel that your approach to discipline is effective? yes no

V. Speech and Language Development

Please indicate age when the following skills were first performed

babble _____ imitate words _____ use first word meaningfully _____

put words together _____ talk in single words _____ talk in phrases _____

complete but grammatically incorrect sentences _____

complete but grammatically correct sentences _____

1. Did speech and language development seem to progress normally and then stop or regress? no yes
 At what age? _____

2. Is he/she inconsistent in his/her response to sounds and voices? yes no

3. Does he/she seem to understand what is said to him/her? yes no

4. Does he/she follow spoken directions? yes no

5. Does he/she retell stories or experiences that can be understood? yes no

6. Does he/she often hesitate and/or repeat sounds and words? yes no

7. Is his/her speech: too fast too slow average

8. Is his/her voice: check all that apply too soft too loud average loudness hoarse nasal
 denasal "stuffed as during a cold"

VI. Feeding Development

Please indicate age when your child began to:

eat table foods _____ use a spoon _____ use a fork _____

drink by self out of a cup _____

Does your child have difficulty chewing or swallowing food? _____ Describe _____

Is child a picky eater? _____ If yes, list foods the child eats and will not eat _____

Did or does your child use a pacifier? _____

At what age did your child stop using a pacifier? _____

At what age did your child stop drinking from a bottle? _____

Has your child exhibited thumb sucking behaviors? _____

If so, at what age did these behaviors begin and end? _____

VII. Evaluative and Educational History

Evaluations or therapies: Speech and language, Hearing, Occupational; Physical; Psychological, etc.
(Please attach IEPs, reports, or any updated information.)

Whom	Where	When

Other schools or programs attended:

Name	Address	When

VIII. Family History

1. Father's occupation: _____ Age: _____
Level of education: _____

2. Mother's occupation _____ Age: _____
Level of education: _____

3. Are both parents living at home? []yes []no

4. Names of siblings: _____ DOB: _____
_____ DOB: _____
_____ DOB: _____

5. Others in the home:
_____ age: _____ relationship to child: _____
_____ age: _____ relationship to child: _____

6. Are any foreign languages spoken at home? []yes []no
languages: _____
What language do you think your child understands best? _____
What language do you think your child uses more often? _____

7. Have any family member or relatives had any of the following difficulties: check all that apply

- speech problems: relationship to child: _____
- language problems: relationship to child: _____
- hearing problems: relationship to child: _____
- learning disability: relationship to child: _____
- reading problem: relationship to child: _____
- emotional problem: relationship to child: _____
- mental retardation: relationship to child: _____

8. Please list your concerns regarding your child's communication skills. Explain.

Parent signature

Date

The SLC is a not-for-profit organization and does not discriminate on the basis of race, color or ethnic origin in the administration of its policies. (A limited number of scholarships are available.)