CHILD CASE HISTORY INTAKE FORM

Speech-Language-Hearing Clinic
516 High Street, MS 9171
Bellingham, WA 98225
Ph: 360.650.3881 Fax: 360.650.4334

Thank you for taking the time to fill out this intake form. The information you provide will help us to plan for your child's assessment.

Child's Name: _____ Age: _____ Birth date: _____

Gender: _____ Pronouns: _____ Child's spoken Language(s): _____

Preferred contact address: _____

Person completing this form: _____ Date form completed: _____

Did someone refer you to our clinic?

- ☐ No
- ☐ Yes. Name of referral source: _____

What do you hope to gain from this assessment?

Primary caregiver information (please include all people who might transport your child to/from our clinic):

Name	Relationship to Child (e.g., mother)	Pronouns	Spoken Language(s)	Occupation	Contact Information
					Phone: Email:
					Phone: Email:
					Phone: Email:
					Phone: Email:

Other people who live with or frequently care for your child:

Name	Relationship to Child	Pronouns	Spoken Language(s)	If sibling, age?

Is there a parenting plan that we should be aware of or any parent/guardian restrictions?

- ☐ No
- ☐ Yes. Please **attach a copy** of your parenting plan or describe restrictions.

Have there been any major changes in your home or with your family during the last year that we should be aware of (e.g., changes of address, change of school, parent separation/divorce, accident, illness/death, births, adoptions, marriage, etc.)?

- ☐ No
- ☐ Yes. Please specify.

PRIOR DIAGNOSES AND EDUCATION/THERAPEUTIC HISTORY

Has your child ever received the following diagnoses? (Check all that apply)

____	Language Delay/Disorder	____	Speech Sound Delay/Disorder	____	Apraxia
____	Fluency Disorder	____	Voice Disorder	____	Autism Spectrum Disorder
____	Dyslexia	____	Dysgraphia	____	Cerebral Palsy
____	Reading delays/ difficulties	____	ADD/ADHD	____	Intellectual or Cognitive delays/disability
____	Gross motor delays/disabilities	____	Fine motor delays/disabilities	____	Overall developmental delays/disability
____	Hearing Impairment	____	Vision Impairment	____	Social/emotional delays/disorders
____	Learning Disability	____	Other:	____	Other:

Does your child currently attend: ___ Preschool ___ Day Care ___ Early Intervention ___ Home School

___ Elementary School ___ Middle School ___ High School ____ Other _____

Current School: _____ Grade/ Level: _____

Primary classroom teacher(s): _____

Best way to contact teacher

☐ Email: _____

☐ Phone: _____

Does your child have an Individualized Education or Family Service Plan (504 Plan, IEP or IFSP)?

- ☐ No
- ☐ Yes. *If you have a copy of your child's educational plan (504, IEP, IFSP), then please attach it.* If not attached, please have your child's school send a copy to: WWU Speech-Language Clinic, 516 High Street, MS 9171, Bellingham, WA 98225-9171, or fax to 360-650-4334. Also, please answer the following questions.

Does your child receive the following services through their **educational plan**?

School Service Provider	Name of provider	Best contact information (e.g., phone number or email address)
Special Education or Resource Teacher		
Speech-Language Pathologist		
Occupational Therapist		
Physical Therapist		
Literacy Specialist		
Deaf Educator, Aural Rehabilitation Specialist		
Other:		
Other:		

Does your child receive any **private therapeutic or educational** services?

- ☐ No
- ☐ Yes. *If you have a copy of your child's most recent assessment report then please attach it.* If not attached, please have your child's current or past providers send a copy to: WWU Speech-Language Clinic, 516 High Street, MS 9171, Bellingham, WA 98225-9171, or fax to 360-650-4334. Also, please answer the following questions.

Private Service Provider	Name of provider	Best contact information (e.g., phone number or email address)
Speech-Language Pathologist		
Occupational Therapist		
Physical Therapist		

Private Service Provider	Name of provider	Best contact information (e.g., phone number or email address)
Literacy Specialist		
Deaf Educator		
Counseling/ Mental Health		
Behavioral Therapy		
Other:		
Other:		

PRENATAL AND BIRTH HISTORY

____ My child experienced typical prenatal development and birth. No concerns were noted.

____ My child's prenatal development and birth history is unknown due to adoption.

____ My child experienced atypical prenatal development and/or birth. Please explain below:

After birth, my child experienced (please check any that apply):

___ unknown

___ Difficulty Breathing	___ Difficulty Sucking	___ Difficulty Feeding
___ Seizures	___ Birth Defect	___ An Extended Hospital Stay
___ Jaundice	___ Infections	Other _____

HEALTH HISTORY

Has your child ever had any of the following medical conditions/ diagnoses? ____ unknown

____ Allergies/ asthma	____ Swallowing difficulties	____ GERD/ reflux
____ Dietary restrictions or other eating problems	____ Sleep apnea or other sleep problems	____ Head injury/ concussion
____ Ear infections	____ Dizziness	____ Hearing loss
____ Tinnitus (ears ringing)	____ Pneumonia	____ Headaches
____ Cleft lip or palate	____ Seizures	____ COVID-19
____ Vocal nodules	____ Voice Disorder	____ Difficulty breathing during exercise
____ Infection diseases (e.g., mumps, measles)	____ Other:	____ Other:

If you checked any of the above, please provide additional details, including dates and treatment.

Has your child ever experienced other accidents, illnesses, surgeries, or hospitalizations?

- ☐ No
- ☐ Yes. Please provide us with details (below), including dates.

Does your child wear glasses?

- ☐ No
- ☐ Yes. Please tell us why they were prescribed (below).

Has your child ever received a hearing test? (For any child under five years old, we require a full hearing test within six months of a speech-language evaluation. This can be completed in our clinic or with an audiologist. We will discuss this with you prior to scheduling.)

- ☐ No
- ☐ Yes. Please provide details (e.g., dates and results).

Does your child use hearing aids or other listening devices?

- ☐ No
- ☐ Yes. Please tell us why they were prescribed (below).

If your child's hearing has not been tested recently, do you suspect your child has a hearing loss?

- ☐ No
- ☐ Yes. Please describe your concerns below.

Does your child currently receive services from the following **medical** professionals?

Private Service Provider	Name of provider	Best contact information (e.g., phone number or email address)
Pediatrician or Primary Doctor		
Ear, Nose, and Throat Doctor (ENT)		
Neurologist		
Dentist		
Ophthalmologist/ Optometrist		
Audiologist		
Other:		
Other:		

Does your child take any medications?

- ☐ No
- ☐ Yes. Please fill out the table below.

Medication	**Dosage**	**Purpose**

LANGUAGE CONCERNS AND DEVELOPMENT

Do you have concerns about your child's ability to understand or use language to communicate with others?

- ☐ No. Please skip to the next section.
- ☐ Yes. Please answer the following questions.

Did your child develop the following skills as expected?

Communication related skills	Developed skill at an expected age	Delayed or atypical development	If delayed/ atypical development, please describe (e.g., babbled late and not very often)	Unknown or can't recall
Babbled as an infant				

Communication related skills	Developed skill at an expected age	Delayed or atypical development	If delayed/ atypical development, please describe (e.g., babbled late and not very often)	Unknown or can't recall
Used single words to communicate (1-2 years of age)				
Spoke in short sentences (2-years of age)				
Used conversational speech (3-years of age and above)				

How does your child typically communicate? (Please check any that apply):

___ Looking at objects ___ Pointing at objects ___ Gestures

___ Crying ___ Vocalizing ___ Leading you to desired object

___ Single words ___ 2-3 Word combinations ___ Sentences

___Conversation ___ Baby signs ___ American Sign Language

____ Uses an augmentative/ alternative communication system ____ Other (please specify

Does your child have difficulty understanding directions or conversation (as expected for their age)?

- ☐ No
- ☐ Yes

Is there a family history of language delays/disorders?

- ☐ No
- ☐ Yes. Please describe and include family members and diagnoses.

What strategies do you use to help your child improve their language skills?

SPEECH SOUND CONCERNS AND DEVELOPMENT

Do you have concerns about your child's ability to correctly produce speech sounds (articulate sounds in words)?

- ☐ No. Please skip to the next set of questions

☐ Yes. Please answer the following questions.

Which of the following describes your child's speech?

___ My child's speech is easy to understand, but one or more sounds are said incorrectly or distorted.

___ My child's speech is fairly easy for familiar listeners to understand (e.g., parents), but difficult for unfamiliar listeners (e.g., family friends, store clerk) to understand. Many sounds are produced incorrectly or distorted.

___ It is difficult for familiar listeners to understand (e.g., parents) my child's speech. Most sounds are produced incorrectly or distorted.

___ My child doesn't produce many sounds at all. Few or no words are produced or understood.

My child…

___ is easily frustrated when other people don't understand them.

___ doesn't seem aware of their speech problem.

___ is teased/bullied about their speech.

___ tries to say sounds or words more clearly when asked.

___ can correctly produce speech sounds when asked.

___ doesn't like being asked to say sounds/ words correctly.

Which sounds are difficult for your child to say? (Check all that apply)

Sound	Example word	My child doesn't make this sound yet	My child attempts to make this sound, but doesn't produce it correctly	My child replaces this sound with another sound
p	**p**otato			
b	**b**anana			
m	**m**a**m**a			
n	**n**a**n**a			
w	**w**ater			
t	**t**able			
d	**d**a**d**a			
k	**k**itty			
g	**g**o			
h	**h**appy			
f	family			
s	**s**on			
l	**l**ittle			
y	**y**ellow			
sh	**sh**ip			
v	**v**ery			
r	**r**abbit			
ch	**ch**ew			

Sound	Example word	My child doesn't make this sound yet	My child attempts to make this sound, but doesn't produce it correctly	My child replaces this sound with another sound
dg	**j**uice			
th	**th**ing or **th**is			
vowel sounds	f**ee**t, wh**o**, p**ie**, c**ow**, t**oy**, g**e**t			

Is there a family history of speech delays/disorders?

- ☐ No
- ☐ Yes. Please describe and include family members and diagnoses.

What strategies do you use to help your child improve their speech skills?

FLUENCY CONCERNS AND DEVELOMENT

Do you have concerns about your child's speech fluency (ability to talk without stuttering)?

- ☐ No. Please skip to the next section.
- ☐ Yes. Please answer the following questions.

Does your child repeat sounds or words?

- ☐ No
- ☐ Yes. Please mark any behaviors that you have observed:

  ___ Repeats individual sounds or syllables (ex. B-b-baby).

  ___ Repeats single words (ex. My, my, my).

  ___ Repeats phrases (ex. Can I, can I, can I go?).

Does your child "get stuck" when attempting to say a word?

- ☐ No
- ☐ Yes. Please mark any behaviors that you have observed:

  ___ Prolongs sounds (ex. Mmmmmmy).

  ___ Shows physical or emotional tension.

  ___ Blocks the sound at the beginning or middle of the word when trying to speak.

When did your child first start having difficulty speaking fluently?

Is there a family history of stuttering?

- ☐ No
- ☐ Yes. Please describe and include family members and diagnoses.

What strategies do you use to help your child improve their fluency skills at home?

VOICE CONCERNS

Do you have concerns about your child's vocal quality?

- ☐ No. Please skip to the next section.
- ☐ Yes. Please describe your concerns.

Does your child's voice sound… (Check all that apply)

- ☐ Hoarse
- ☐ Breathy
- ☐ Too loud
- ☐ Too soft
- ☐ Raspy

SOCIAL AND EMOTIONAL BEHAVIOR AND CONCERNS

How would you describe your child?

___ Quiet ___ Active ___ Difficulty controlling emotions ___ Loving

___ Shy ___ Wants to please others ___ Friendly/outgoing ___ Imaginative

___ Plays well with other children/ gets along with others ___ Difficulty separating from parent

____ Other:

Do you have concerns about your child's social/emotional development or ability to get along with others?

- ☐ No.
- ☐ Yes. Please describe below.

ACADEMIC SKILLS

Do you have concerns about your child's ability to read/write or learn at school?

- ☐ My child is not in school yet. Please skip to the next set of questions
- ☐ No. Please skip to the next set of questions
- ☐ Yes. Please answer the following questions.

My child is:

- ☐ Is doing as expected in school.
- ☐ Is starting to fall behind in school.
- ☐ Has been identified with a learning disability and is receiving services at school.

Please describe your current concerns about your child's ability to read/write/learn?

Is there a family history of literacy and/or learning problems?

- ☐ No
- ☐ Yes. Please describe and include family members and diagnoses.

What strategies do you use to help your child improve their literacy skills at home?

OTHER

Please provide any additional information you feel might be helpful to us.

For Office Use Only: Received By: _____ Date Received: _____