Help Me Speak LLC
Barbara A. Taylor, M.S., CCC-SLP, COM
& Associates
410-442-9791
www.helpmespeak.com

Child's Full Name:____

Nickname: ______________________ Grade: _____ Sports? Y N Type: _________________

Address: ________________________ Date of Eval: _______________________________

________________________ Client's Home Phone #: ________________________

Parents: ________________________ Cell Phone #: _______________________________

DOB: __________________________ Age: ______________

Siblings: _____________________ Gender: ____ Age: ________
Siblings: _____________________ Gender: ____ Age: ________
Siblings: _____________________ Gender: ____ Age: ________

What language(s) is/are spoken at home? ____
By whom? ____

Who referred you to **Help Me Speak**? ____

What are your main concerns that bring you to **Help Me Speak**: ___________________________
____

Have you discussed these concerns with a professional?___ If so, with whom? doctor teacher other ______
Results of this conversation? ____

School Name: ____________________________ Teacher: _________________
School SLP: ______________________________

List any medical diagnoses your child has & the date 1st given: ________________________________

____

What do you hope to accomplish by coming to **Help Me Speak**? ______________________________
____

Person completing form___________________________ Relationship to child___________________

PRENATAL AND BIRTH HISTORY:

Circle any that apply:

During pregnancy:

___Bed rest @ ___wks
___Excessive vomiting
___Illnesses (e.g. German Measles)
___Drug use
___Alcohol use
___Excessive weight loss
___Gestational diabetes
___Low platelets
___Hospitalization @____wks
___Hemorrhaging
___Medications
___Smoking
___Trauma/injuries
___Excessive wt gain
___Premature rupture of membranes
___Other: ______________________________________
___X-ray treatments
___RH incompatibility
___Previous miscarriages _____#
___High blood pressure
___Diabetes

Describe/explain any maternal health problems (listed above or others) during pregnancy. Please list at **how many weeks** in your pregnancy each occurred.

____
____
____
____

Length of pregnancy ___wks ____ days Birth Wt ___lbs ___oz APGAR Scores: 1min____ 5min ______

Delivery: Epidural? Y N Amount of time pushing? ____hrs Baby stuck? Y N Where? ___________

Assisted delivery? Y N Forceps? Y N Vacuum? Y N Other? ______________________________

Appearance of head? ___________________ Appearance of body? ___________________________

When was baby's first cry? ________________________ When was first breath? __________________

Cord around neck? Y N Oxygen needed? Y N How was oxygen given? Blow by/ nasal cannula / Isolette / Other? ___________________ Other birth trauma? _______________________________

When did baby first nurse? ____

General health of child at birth ____
____

Describe any Medical issues at birth: ____
____
____
____

Was your child in the NICU? Y N Which hospital? _____________________________________

Dates/ Length of stay: ____

If so, please explain reason for admission & course of stay: _____________________________
____
____

Date of discharge: ________________ To where? ___Home Children's hospital_________________

Other____

EARLY FEEDING HISTORY:

Breastfed? Y N Painful breastfeeding? Y N Latching difficulties? Y N

How long breastfed?__________________Explain how: _____________________________________

Bottle until what age?____

Formula or breast milk in bottle? ____

Excessive length of time to drink a bottle? Y N Explain: ___________________________________

Regurgitation of liquids or solids through the nose? Y N Explain: ____________________________

Describe any other early feeding problems(during birth-6 mo):

____

____
____
Choking or gagging? Y N ____
On what food textures? ____
Colic? Y N Reflux? Y N Describe each: ____
____
Special formula? Y N ____
Describe transition to baby food & finger food :___________________________
____
At what age?:___________

<u>Has your child *ever* or does your child *currently*</u>: (at what ***ages***)
Mouthed toys? Y N If so, what types? ____
Sucking: Fingers? ___ Blankets? ____ Thumb?____ Pacifier? ____ Other?_____
How long?_________________

MEDICAL INFORMATION:

Does your child have a history of Upper Respiratory Infections (colds)? Y or N
How many?_______ At what ages did they occur? _______________________

Does your child have a history of ear infections, otitis media, or uninfected fluid in the middle ear? _____
In which ear? R L Both How many? ____
At what ages did they occur? __________________ How long did each ear problem last? _____________
____
What medications were prescribed? ____
____
Has your child ever been treated by an ear, nose, and throat specialist (ENT)? Y or N
Who? ____________________________ At what age? ______________________________
For what reasons? ____
Does your child have tubes? Y or N At what age were they placed? ____________
By Doctor: ______________________________________
Are they still present? Y or N In which ear? _____________ Are tonsils/adenoids still present? Y or N
When were tonsils/adenoids removed? ________________________ At what age? __________________
Allergies?__________________________________ Sinus problems? ___________________________
Treatment for above? ____
Food allergies?____
Or food sensitivities? ____
Other sensitivities? ____
Sensitive to Vibration Y N If Yes, explain _________________________________
Sensitive to other Noises? Y N If yes, explain______________________________
My child has a FEAR or AVERSION to: ____

Does anyone in the family have a history of any speech or language problems?
Mother: Y N Father: Y N Sibling: Y N name:_________ Other family? Y N who?________
If "yes", please describe:

DEVELOPMENTAL HISTORY:

*At what **age** did your child develop:*

1st tooth? ________________ Any problems with baby teeth? Y or N

Lost at what ages?____________

Any lost early due to injury? Y N ____

Orthodontic care? Y N n/a

What type?____

At ***what AGE*** did your child develop: (please list)

Head support____ Reach & grasp____ Rolling (back to tummy)_____

Rolling(tummy to back)____ Sitting alone _____ **Crawling______# months? _____How?________

Standing alone____ Walking ________ Potty trained______

Climbing stairs____ Finger foods____ Use spoon ________

Undressed self____

Babbling: reduplicated (e.g. mamamama) _____ variegated (e.g. badagada) ____

Jargoning (e.g sounds like foreign language) ____ First word _____ Use single words ______

Use 2 words together ____ Talking in sentences _____

Handedness: R or L or not yet established

ORAL BEHAVIORS:

Mouth breathing? Y N When?: while watching tv, in car, etc?____

Teeth grinding? Y N Bites fingernails or cuticles? Y N

Chews on: pencils erasers knuckles blanket fingers other_______

Lick lips excessively? Y N Lips chapped? Y N Chew gum excessively? Y N

Prop chin or head on palm or fist? Y N

EATING HABITS:

glasses liquid with meals? ______ Wash down food? Y N

Fast or slow eater? Chew food adequately? Y N Burp excessively after meals? Y N

Digestive problems? Y N __________ Resist difficult to chew foods? ____________

Is your child a *picky eater*? Y N

My child eats the same foods for meals as the rest of my family: Y N

I fix my child a separate meal than the rest of my family: Y N

Food preferences? Please list **10 or more** Proteins: (e.g. meats, poultry, fish, & dairy)

____

____

Please list **10 or more** Fruits/Vegetables: ____

____

Please list **10 or more** Carbs: ____

____

Food dislikes? ____

____

Favorite tastes/flavors? ____

Preferred textures? ____

Preferred temperature? ____

Special diet/ food restrictions? ____

Other? ____

SPEECH AND LANGUAGE DEVELOPMENT:

13. Please list & describe each kind of sounds your child made before one year of age – cooing prolonged vowel sounds, babbling repeated syllables, squealing, etc.

14. Was there anything unusual about the sounds your child made during this period? If "yes", please explain.

15. At what age did your child say his / her first real word? Word(s): __________

16. Did your child continue to add new words on a regular basis? If "no":

a. How often did your child add a new word?

b. Did your child frequently use another way to communicate?

17. Did your child's speech or language development seem to stop for a time? If "yes":

a. When and **why** do you think it stopped?

b. How did your child communicate with you during this time?

18. How many different words is your child saying now?

19. Do you consider your child to be talkative or quiet?

20. How does your child usually let you know what he/ she wants?

If you answer "pointing" or "gesturing":
a. Does your child try to talk in combination with pointing?

b. does anyone in the family talk for your child or interpret his / her gestures?

21. Has your child ever talked better than he / she does now? If "yes", please explain.

22. What concerns do you have about the way your child's tongue or mouth works for speech or for eating? please

describe.

23. What have you done to help your child learn to talk?

24. Has anything about your child's speech or language development seemed unusual to you? If "yes", please describe.

25. How much time does your child spend with other children?

COMPREHENSION AND UNDERSTANDING:

Compared to children of the same age:

27. Is your child easily confused when there are many things taking place around him / her?
If "yes", please explain:

28. How does your child respond when you give him / her directions?

29. How does your child respond to simple questions?

30. How would you describe your child's intelligence or thinking skills?

31. List any other specialists who have seen your child:

Medical

Hearing

EDUCATIONAL HISTORY:

Educational Setting	Location/School	Teacher(s)
Child Care Facility		
Early Childhood Classes		
Birth to 3 Program (Infants & Toddlers)		

School: Age entered: _______ Any grades repeated? ________
How often does/did your child attend classes?
__Daily __4 x per week __3 x per week
__2 x per week__1/2 days __Full days

How many children are in your child's class? ___________________________
Child's attitude toward school: ___________________________
Any learning or social problems? ___________________________
Greatest academic interest: ___________________________
Least academic interest: ___________________________

Child's Strengths:

Weaknesses:

What type of classroom is your child in? (e.g. Traditional, open classroom, transdisciplinary, etc.)
____
____

Does your child exhibit any learning style preferences? __Visual __Auditory __Both

Does your child's developmental performance seem to interfere with his/her school performance? Y N
If yes, please explain: ___________________________
____

Have teachers expressed any concerns about your child's learning behavior? Y N
If yes, please explain: ___________________________
____

Current hours/week of therapy: (school) Speech ___ Occupational ____ Physical ____ Psychology ____
Educational ____ Other:_________ hrs ___
Current hours/week of therapy: (private) Speech ___ Occupational ____ Physical ____ Psychology ____
Educational ____ Other:_________ hrs __

Has your child ever been evaluated for or attended therapy for & where/with whom:

Type of service	Previously With whom? Where?	Currently With whom? Where?
Speech-Language Therapy (speech, language, feeding, or hearing)		
Audiology (hearing, balance)		
Occupational Therapy		
Physical Therapy		
Psychological or Behavioral Counseling		
Nutritional Services		
Vision Therapy		

Other (describe)		

Please list dates, locations, therapists, and results: ______________________________
____
____

Is your child overly awkward or clumsy? Y N

INTERACTION AND COMMUNICATION DEVELOPMENT:

Do any of the following describe your child as an *infant, toddler, or young child*? If "yes", **please explain**. **In *relation to each question*, please state your child's *age at that time*.**

1. Was your child ever separated from you for a long time?

2. Did your child require any/frequent hospitalization?

3. Did your child resist cuddling?

4. Was your child often difficult to calm?

5. Was your child often colicky?

6. Did your child seem very restless?

7. Did your child seem very inactive?

8. Was your child nonresponsive when you "talked" with him / her?

9. Did your child often avoid eye contact with you or others?

10. Did your child often play with toys in an unusual manner? How?

11. Did your child use gestures to communicate? How?

12. Did your child show interest in the people and things around him / her? *If "no", please explain.*

<u>COMMUNICATION STATUS:</u>
How would you describe your child's current communication ability? (check all that apply)

_____Almost never communicates
_____Sometimes communicates
_____Communicates frequently

_____It is *very* easy for <u>me</u> to understand my child when I <u>know</u> the topic of conversation.
_____It is *fairly* easy for <u>me</u> to understand my child when I <u>know</u> the topic of conversation.
_____It is *difficult* for <u>me</u> to understand my child when I <u>know</u> the topic of conversation.

_____It is *very* easy for <u>me</u> to understand my child when I <u>don't know</u> the topic of conversation.
_____It is *fairly* easy for <u>me</u> to understand my child when I <u>don't know</u> the topic of conversation.
_____It is *difficult* for <u>me</u> to understand my child when I <u>don't know</u> the topic of conversation.

_____My child is usually understood by <u>other people</u> who don't know him/her well.
_____My child is usually NOT understood by <u>other people</u> who don't know him/her well.

Please describe how your child communicates: ____
____
____
____

Which of the following best describes your child's speech?
____easy to understand
____difficult for parents to understand
____difficult for others to understand
____almost never understood by others
____different from other children of the same age

Which of the following statements best describes your child's reaction to his/her speech?
____ Is easily frustrated when not understood
____Does not seem aware of speech/ communication problem
____Has been teased about his/her speech
____Tries to say sounds or words more clearly when asked
____Is successful in saying sounds or words more clearly when he/she tries

Is your child aware of his/her communication difficulties? ____yes ____no

If Yes, how does this awareness impact on his/her social/emotional status? _____________
____
____

Does your child have difficulty producing certain sounds? ____yes ____no
If so, which ones are difficult? ____

Does your child hesitate and/or repeatedly say sounds or words? ____yes ____no
If so, which ones? ____

Does your child "get stuck" when attempting to say a word? ___yes ___no
Explain: ____

Indicate your agreement with the following statements (circle one choice):

1. My child is able to communicate effectively to express pleasure or displeasure.
Strongly disagree Disagree Not Sure Agree Strongly Agree

2. My child is able to communicate to get help when needed.
Strongly disagree Disagree Not Sure Agree Strongly Agree

3. My child's biggest communication priority is to request things he/she needs.
Strongly disagree Disagree Not Sure Agree Strongly Agree

4. My child's biggest communication priority is to get or give information (e.g. ask/answer questions)
Strongly disagree Disagree Not Sure Agree Strongly Agree

5. My child's biggest communication priority is to initiate & maintain conversations.
Strongly disagree Disagree Not Sure Agree Strongly Agree

A typical day for my child is: ____
____
____
____
____
____

Please list any of your child's achievements that are especially important to him/her or you:
____
____
____
____

AUGMENTATIVE COMMUNICATION/ASSISTIVE TECHNOLOGY:
Has your child in the past or does he/she currently use an augmentative communication device or any assistive technology at home or at school? ___Yes ____No
If **yes**, what type/name of device/software: ____
In what situations is your child using this device: (circle all that apply) All School Home
Other:_______

If he/she has used a device in the past only, briefly explain why it is not currently used:
____
____
____

Who evaluated your child for this augmentative communication device/system?
____
____

HEARING HISTORY:

Does your child say "huh" or "what" at least 5 or more times per day? __Yes __No

Do you ever question your child's ability to hear normally? __Yes __No

If yes, please explain: ____

____

Is your child easily distracted? __Yes __No

Does your child have difficulty following directions? __Yes __No

When was the last time your child's hearing was checked?

__within the last year
__1-3 years ago
__4+ years ago

Where? ____

By Whom? ______________________________

Phone: ____________

Results ____

SOCIAL/ EMOTIONAL DEVELOPMENT:

Check behaviors that you feel best describes your child:

__Overly active
__Overly quiet
__Excessive tantrums
__Destructive
__Very shy
__Perfectionist
__Friendly, outgoing
__Imaginative & creative
__Plays well with other children
__Prefers older children
__Prefers younger children
__Defiant
__Easily controlled /Passive
__Nervous
__Dependent upon routines
__Difficulty separating from parent
__Thumb-sucking
__Drooling
__Teeth grinding
__Mouth breather
__Interrupted/Unusual eating habits
__Interrupted/ Unusual sleeping habits

Please describe any discipline problems you have with your child: ______________

____

____

Describe any evaluations or therapy for behavior or emotional difficulties: __________

____

____

Does your child have a BEHAVIOR PLAN? ____YES ____NO If so, please attach or describe here:

____

____

What method of discipline do you use? ______________________________

What method of discipline does your spouse use? ________________________

PLAY BEHAVIORS:

Please list from 1-5 the type of play your child likes to engage in most often. (5=most often 1=least often)

__Putting toys in mouth __Banging toys together __Throwing toys
__Shaking toys __Pushing/pulling toys __Role-playing
__Uses one object for another __Games with rules __Rough & tumble play
__Appropriate use of objects __Make believe games __Looking at books
__Acting out familiar routines __Computer games __Other: _________

What is the average length of time your child can play at one activity? _______________

Which activities seem to hold your child's attention for the longest periods of time?
____

Which activities do not seem to hold your child's interest? _________________________
____

Is your child's play easily distracted by:
___ Visual stimuli (e.g. other toys, objects)
___ Auditory stimuli (e.g. voices, sounds outside, TV)
___ Nearby activities
___ Other people in the room

Whom does your child prefer to play with? (circle any that apply)

Mother Father Brother/Sister Self Other child Other adult

List some of your child's favorite toys, TV programs, and videos: ___________________
____
____

Please list any other information that has not been asked in the above questions: _______
____
____
____
____
____
____
____

THERAPEUTIC INFORMATION:

Please list some things that your child **really likes and dislikes** in each of the following categories:
(***We use this section for planning activities in therapy***)

Toys: Likes- ____
____

Dislikes-____
____

TV Shows: Likes-____

____

Dislikes-____

____

Places to Go: Likes-____

____

Dislikes-____

____

Activities: Likes-____

____

Dislikes-____

____

Other Special Interest or Hobbies: _______________________________________

____

Dislikes-____

____

Please return a copy of your child's ***current IEP or IFSP and any other ***recent*** (within past 1yr) ***& relevant medical &/or therapy reports*** with this case history. Thank you.

Listed below are words that young children might understand or say. **IF your child is not yet using *2-3 word combinations***, please put a ***check*** beside those words you think your child *understands*. ***Circle*** the words your child *says* when he / she talks to you. (138) R: ___/138 E: ___/128
If your child is *already speaking* in 2-3+ word combinations, ***SKIP THIS SECTION***.

all
all gone
apple
arms
baby
babysitter's name
ball
balloon
banana
bear (teddy)
belly / tummy
big
bike
bird
book
boots
boy
bug
bunny
bye / bye-bye
candy
car
cat / kitty
chair
cheese
choo-choo
church
clock
coat
cold
comb
cookie
cracker
cup
dada / daddy
diaper
dirty
dog / doggie
don't
done
down
drink
ears
eat
eat cookie
eyes
fall down
feet
fingers
flower

girl
go bed
go bye-bye
go night-night
go out
grandma
grandpa
gum
hair
hands
hat
hi
horse / horsie
hot
hot dog
huh?
I
in
key
legs
little
mama / mommy
McDonald's / other
me
milk
mine
more
more cookies
mouth
night-night
no
nose
old
on
out
paper
phone
pizza
go
please
potty
purse
rock
see
shhhh
shirt
shoe
sit / sit down
sky
sleep
snow
so big
sock
spoon
stick
stop
stove
swing
teeth
thank you
thirsty
tissue
tired
toes
toy
truck
TV
uh-oh
under
up
want
wet
what
what's that
yes
you
yucky

List the names of family members, friends, or pets your child understands and circle the ones he/she says.

List any other words your child understands and circle what he/she says.
List any words that your child can write, if any.