Please complete this form and return it to:

Childhood Language Center
1313 Quarrier St. Suite A
Charleston, WV 25301-6002
Or **Fax to 304-756-8695**

Date:_____

Client's Name:_____Birthdate:_____ Age:____
Client's Social Security Number:_____ Sex: M or F

Parents/Guardians' Names:_____

Phone: ***please number*** *in order of preference to be called* _____Home

_____ Cell (*Father/Mother*) _____Cell(*Father/Mother*)

_____Work(*Father/Mother*) Other_____

Address: _____
P O Box/Street City State Zip code County

Parents/Guardians are: ___ Married ___ Divorced ___ Separated ___ Deceased

Father's Education:_____ Mother's Education:_____
Father's Occupation/Employer:_____
Mother's Occupation/Employer:_____

Referring Physician/Pediatrician:_____Phone:_____
Case History filled out by:_____Relationship to child:_____
How did you hear about the Center?_____
Please describe the concerns you have for your child. Please include any diagnosis that your child may have received from a doctor or other professional, words he/she has trouble saying or ways that your child has problems communicating:_____

_____

_____

_____

_____
_____
_____
_____
_____
_____
_____
_____
_____

Birth and Medical Information

Age of mother during pregnancy:_____ Health of Mother during Pregnancy:_____
Please list any accidents or illnesses during pregnancy:_____
Was child full term_____ If not, how many weeks:_____
Child's Birth Weight:_____ Please describe any difficulties at birth or procedures or special care needed for your child following delivery, such as feeding problems or incubation:_____
_____
_____
_____

Has your child been diagnosed with any of the following:

ADD/ADHD Allergies Apraxia
Aspbergers/PDD-NOS Autism Behavior Disability
Cerebral Palsy Cleft Lip/Palate Clipped Lingual Frenum
Cochlear Implant Cognitive Impairment Depression/Anxiety
Down Syndrome Ear Aches (Otitis Media) Fragile X
Frequent Colds/Influenza Hearing Impairment/Loss Hearing Aids
High Fevers Hydrocephaly Meningitis
Microcephaly Muscular Dystrophy P E Tubes
PEG/NG Tube Poor Vision Seizures
Sinusitis Swallowing/Feeding Problems
Tonsillectomy Traumatic Brain Injury

Please list any other diagnosis your child has or that you are concerned your child may have (please indicate if just a suspicion) and any medication your child is currently taking:
_____
_____
_____

Has your child had all immunizations required for his/her age:_____

Developmental Information

Please list the age at which your child did the following:

Held head up _____ Crawled_____ Sat alone_____ Walked_____ Toilet Trained_____ Held crayon/pencil_____

Fed self with spoon _____ Drank from a cup _____

Cooed_____ Babbled _____ Said first word _____ Put 2 - 3 words together _____

Has your child ever had difficulty with the following: Sucking_____ Chewing _____

Swallowing_____ Climbing _____ Stacking Blocks _____

Interacting with children of same age_____

Is your child's speech understandable to family?_____ to others?_____

Does your child have problems with specific sounds? Yes No If yes, please list:_____

How many words do you think your child uses?_____

Please list some of your child's most frequently used words and phrases: _____

_____

_____

_____

Does your child use any means other than speech to communicate (such as gestures, signs, pictures)? please describe:_____

_____

_____

Does your child understand directions?_____ questions? _____

use sentences? _____identify objects? _____use eye contact ?_____

Has your child ever had a Speech/Language evaluation ( )Yes ( )No If yes, by whom? _____date?_____

Physical or occupational?_____

Hearing screening/evaluation? If yes, Date_____Pass or Fail_____

Has your child ever received or is currently receiving, speech therapy (or any other developmental therapy)? If so, please list agency or professional and describe what was addressed:_____

_____

_____

Social Information

Does your child attend school? (please give name)_____ grade?_____

Belong to any groups/clubs?_____

Please give names and ages of your child's siblings:_____

_____

_____

Please describe your child's eating habits:_____

_____

_____

Please describe your child's personality and behavior. Try to include information that will help us during testing, such as their likes and dislikes._____

_____

_____

Days of week & times of day you can bring child for therapy:
