GIBBSBORO ELEMENTARY SCHOOL DISTRICT

Grades PS through 8

SPEECH - LANGUAGE CASE HISTORY SUMMARY

BACKGROUND INFORMATION:

Child's Name ______________________________ Phone # ________________

Address ____

____

Date of Birth______________________________ Age ________________

Parents/Guardians ____

SPEECH - LANGUAGE HISTORY

YES	NO	
____	____	Is English the primary language spoken in the home? If no what is primary language? ____
____	____	Is English the first language your child learned to speak? If not, please explain.
____	____	Are there any relatives who speak other than English?
____	____	If yes, do they live in your home?
____	____	Does your child have any speech, language, or hearing problems that you are aware of? If yes, please state the problem. ________________________ ____
____	____	Are there any relatives who have speech, language, or hearing problems? If yes, please state relationship and type of problem. ________________________ ____

CONTINUED ON BACK – PLEASE COMPLETE

YES	NO	
____	____	Did your child babble as an infant?
____	____	Does your child understand directions and carry them out appropriately?
____	____	Does your child have any difficulty expressing him/herself so that he/she can't share feelings, needs or experiences? Please explain.
____	____	Does your child have trouble pronouncing words? If so, does this interfere with others being able to understand him/her?
____	____	Has your child previously received or is he/she now receiving speech therapy services? Where? When? ________________________________

AGE	
________	When did your child speak his/her first word?
________	When did your child first begin combining two or more words together to form phrases or sentences?

YES	NO	
____	____	Has your child had ear infections or ever shown any indications of having difficulty hearing?
____	____	Has your child had more than two upper respiratory problems per year? (colds, tonsillitis, ear infections, etc.?)
____	____	Does your child have allergies? If yes, what allergies and is medication taken? ____ ____
____	____	Does your child have any visual problems? Does your child wear glasses?________
____	____	Does your child have dental problems? How often does your child visit the dentist? ____

COMMENTS

Please comment on any information about your child's history you may feel is important or any concerns you have about your child.

Date: ________________________ Signed ______________________________________

Relationship to child