



The Autism Learning Center^{LLC}

Child Case History Form

General Information

Child's Name: _____ Date of Birth: _____

Address: _____

Mother's Name _____ Mother's Occupation: _____

Father's Name: _____ Father's Occupation: _____

Phone Numbers: _____

_____ Email: _____

Sibling(s): _____ Age(s): _____

Child care arrangements if both parents work: _____

What language is spoken in the home? _____

How much of the child's language is understood by other adults? _____

Describe the child's speech-language problem:

How does the child usually communicate (gestures, single words, short phrases, sentences)?

When was the problem first noticed?

Has the problem changed since it was first noticed?

General Information

Have any other specialists seen the child? If yes indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

What is the Child's Diagnosis?

Are there any other speech, language, or hearing problems in your family? If yes please describe.

Describe any behavior which is a problem to the parents.

List child's favorite activities

Please check behaviors that describe your child.

looks happy appears sad non-compliant shows self-stimulating behaviors
 even tempered is affectionate throws/breaks cries frequently
 very active calm and quiet self-injurious has trouble sleeping
 friendly/outgoing very independent distractible seems unusually fearful
 dependent on adults aggressive to others tantrums/screaming

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.):

Length of pregnancy: _____ Length of Labor: _____

General condition: _____ Birth Weight: _____

Circle type of delivery: Head first Feet first Breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Allergies _____ Asthma _____ Chicken Pox _____

Colds _____ Convulsions _____ Croup _____

Dizziness _____ Draining Ear _____ Ear Infections _____

Encephalitis _____ German Measles _____ Headaches _____

High Fever _____ Influenza _____ Mastoiditis _____

Measles _____ Meningitis _____ Mumps _____

Pneumonia _____ Seizures _____ Sinusitis _____

Tinnitus _____ Tonsillitis _____ Other _____

Has the child had any surgeries? If yes what type and when.

Describe any major accidents or hospitalizations:

Is the child taking any medications? If yes, please identify:

Have there been any negative reactions to medications? If yes, identify:

Has your child's hearing been tested? _____

Describe child's general health:

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl _____ Sit _____ Stand _____

Walk _____ Feed self _____ Dress Self _____

Is your child toilet trained? If yes how old was your child when toilet trained? _____

Is your child a picky eater? _____

Does your child show hand dominance? _____

Does your child fall frequently? _____

Use single words (e.g., no, mom, doggie, etc.)? _____

Combine words (e.g., me go, daddy shoe, etc.)? _____

Name simple objects (e.g., dog, car, tree, etc.)? _____

Use simple questions (e.g., Where's doggie? Etc.)? _____

Engage in a conversation? _____

Does your child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Are there or have there been any feeding problems (e., problems with sucking, swallowing, drooling, chewing, etc.)? If yes describe:

Is your child on a special diet? _____

Does your child have food allergies? _____

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sound, etc.):

Education History

School: _____ Grade/ Class: _____

Teacher(s): _____

How is your child doing academically (or pre-academically)?

Does the child receive special services? If yes, describe classroom.

How does the child interact with others (e.g., shy, aggressive, u uncooperative, etc.)?

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals.

Provide additional information that might be helpful in the evaluation or remediation of the child's problem:

Did your child attend: **Y/N** Early intervention, **Y/N** Pre-school, **Y/N** Kindergarten?

Any grades repeated? _____

Signature: _____ Date: _____