

**SPEECH AND LANGUAGE CENTER OF NORTHERN VIRGINIA**

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[www.dolleymadisonpreschool.org](http://www.dolleymadisonpreschool.org)

[www.slcnv.org](http://www.slcnv.org)

**Dolley Madison Preschool**  
(703) 356-1351

**Speech & Language Services**  
(703) 356-2833

**Case History**

Child's Name: \_\_\_\_\_  
Last First Middle Nickname

Date of Birth: \_\_\_\_\_ Chronological Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Other Telephone \_\_\_\_\_

Father's Name: \_\_\_\_\_

Place Employed: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Place Employed: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Please provide address and phone number if a parent has a different address \_\_\_\_\_  
\_\_\_\_\_

Person(s) or agency having legal custody of child: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**EMERGENCY INFORMATION**

Pediatrician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Emergency contact (name, address and phone number of two designated people to call in an emergency if a parent cannot be reached) Please remember to include the address. These people are also authorized to pick up my child.

1. \_\_\_\_\_ Telephone: \_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_ Telephone: \_\_\_\_\_  
\_\_\_\_\_

Other person(s) authorized to pick up my child: \_\_\_\_\_  
\_\_\_\_\_

Person(s) not authorized to pick up child, if any: \_\_\_\_\_  
\_\_\_\_\_

(Appropriate paper work such as a divorce decree shall be attached if a parent is not allowed to pick up the child)

**BACKGROUND INFORMATION**

**I. Birth and Developmental History**

**a. Was your child adopted?** \_\_\_\_\_ Date \_\_\_\_\_ From where? \_\_\_\_\_

**b. Pregnancy**

Was mother's condition during pregnancy good to excellent? [ ] yes [ ] no

If no, please explain: \_\_\_\_\_

Were medications taken during pregnancy? [ ] yes [ ] no

Were there any illnesses or complications during pregnancy? [ ] yes [ ] no

Please explain \_\_\_\_\_

At how many weeks gestation was baby born? \_\_\_\_\_

What was birth weight? \_\_\_\_\_

**c. Labor and Delivery**

Were labor and delivery normal? [ ] yes [ ] no If not, please explain: \_\_\_\_\_

Was labor induced? [ ] yes [ ] no If yes, please explain. \_\_\_\_\_

Was there evidence of injury or poor health at birth? [ ] yes [ ] no if yes, please explain: \_\_\_\_\_

Was the baby of average activity level? [ ] yes [ ] no

During the first month of life, was his/her health good? [ ] yes [ ] no if no, please explain: \_\_\_\_\_

**d. Infancy and Early Childhood**

Were there any feeding problems? [ ] yes [ ] no \_\_\_\_\_

**II. Medical History**

Diseases child has had: note ages, severity, whether accompanied by high fever, and the effects.

Disease	age	severity & effects	high fever
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\_\_\_\_\_

\_\_\_\_\_

List injuries and/or operations	age	severity hospitalization
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\_\_\_\_\_

\_\_\_\_\_

Is any medication taken on a regular basis? [ ] yes [ ] no if so, what? \_\_\_\_\_

\_\_\_\_\_

Was development of teeth normal? \_\_\_\_\_

List allergies or intolerance to food: \_\_\_\_\_

Actions to take in the event of an allergic reaction/emergency? \_\_\_\_\_

Does your child have a history of ear infections? [ ] yes [ ] no

Has vision been tested?	When	Results
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Has hearing been tested?	When	Results
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**III. Motor Development**

1. Please indicate age when the following skills were first performed.

creeping \_\_\_\_\_ crawling \_\_\_\_\_ sitting unassisted \_\_\_\_\_  
 walking \_\_\_\_\_ hopping \_\_\_\_\_ skipping \_\_\_\_\_  
 using crayon \_\_\_\_\_ using scissors \_\_\_\_\_

2. Has the child established handedness? if so, which hand?  no  yes,  right  left

3. Indicate age when voluntary bladder control was achieved \_\_\_\_\_ bowel control \_\_\_\_\_

**IV. Social and Emotional Development**

1. If your child exhibits or has exhibited the following behaviors, please indicate age of occurrence and how you have attempted to deal with it.

shyness \_\_\_\_\_

thumb sucking \_\_\_\_\_

difficulty separating from parents \_\_\_\_\_

face twitching \_\_\_\_\_

strong fears - nightmares \_\_\_\_\_

temper tantrums \_\_\_\_\_

sleeplessness \_\_\_\_\_

nervousness \_\_\_\_\_

difficulty sitting still \_\_\_\_\_

inability to stay with one activity until completion \_\_\_\_\_

negativeness \_\_\_\_\_

bedwetting \_\_\_\_\_

2. Does he/she have the opportunity to play with other children his/her age?  yes  no

3. If so, does he/she play with them?  yes  no

4. Does he/she play with younger children?  yes  no

5. Does he/she play with older children?  yes  no

6. Are you ever concerned because he/she doesn't play well with other children?  yes  no

7. What are the child's favorite activities? \_\_\_\_\_

8. Primary type of discipline: spanking  isolation (time out)  verbal reasoning  other  \_\_\_\_\_

9. Do you feel that your approach to discipline is effective? yes  no

**V. Speech and Language Development**

Please indicate age when the following skills were first performed

babble \_\_\_\_\_ imitate words \_\_\_\_\_ use first word meaningfully \_\_\_\_\_

put words together \_\_\_\_\_ talk in single words \_\_\_\_\_ talk in phrases \_\_\_\_\_

complete but grammatically incorrect sentences \_\_\_\_\_

complete but grammatically correct sentences \_\_\_\_\_

1. Did speech and language development seem to progress normally and then stop or regress?  no  yes  
 At what age? \_\_\_\_\_

2. Is he/she inconsistent in his/her response to sounds and voices?  yes  no

3. Does he/she seem to understand what is said to him/her?  yes  no

4. Does he/she follow spoken directions?  yes  no

5. Does he/she retell stories or experiences that can be understood?  yes  no

6. Does he/she often hesitate and/or repeat sounds and words?  yes  no

7. Is his/her speech:  too fast  too slow  average

8. Is his/her voice: check all that apply  too soft  too loud  average loudness  hoarse  nasal  
 denasal  "stuffed as during a cold"

**VI. Feeding Development**

Please indicate age when your child began to:

eat table foods \_\_\_\_\_ use a spoon \_\_\_\_\_ use a fork \_\_\_\_\_

drink by self out of a cup \_\_\_\_\_

Does your child have difficulty chewing or swallowing food? \_\_\_\_\_ Describe \_\_\_\_\_

Is child a picky eater? \_\_\_\_\_ If yes, list foods the child eats and will not eat \_\_\_\_\_

Did or does your child use a pacifier? \_\_\_\_\_

At what age did your child stop using a pacifier? \_\_\_\_\_

At what age did your child stop drinking from a bottle? \_\_\_\_\_

Has your child exhibited thumb sucking behaviors? \_\_\_\_\_

If so, at what age did these behaviors begin and end? \_\_\_\_\_

**VII. Evaluative and Educational History**

Evaluations or therapies: Speech and language, Hearing, Occupational; Physical; Psychological, etc.  
(Please attach IEPs, reports, or any updated information.)

Whom	Where	When

Other schools or programs attended:

Name	Address	When
Where	Address	When

**VIII. Family History**

1. Father's occupation: \_\_\_\_\_ Age: \_\_\_\_\_  
Level of education: \_\_\_\_\_

2. Mother's occupation \_\_\_\_\_ Age: \_\_\_\_\_  
Level of education: \_\_\_\_\_

3. Are both parents living at home? [ ]yes [ ]no

4. Names of siblings: \_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ DOB: \_\_\_\_\_

5. Others in the home:  
\_\_\_\_\_ age: \_\_\_\_\_ relationship to child: \_\_\_\_\_  
\_\_\_\_\_ age: \_\_\_\_\_ relationship to child: \_\_\_\_\_

6. Are any foreign languages spoken at home? [ ]yes [ ]no  
languages: \_\_\_\_\_  
What language do you think your child understands best? \_\_\_\_\_  
What language do you think your child uses more often? \_\_\_\_\_

7. Have any family member or relatives had any of the following difficulties: check all that apply

- speech problems: relationship to child: \_\_\_\_\_
- language problems: relationship to child: \_\_\_\_\_
- hearing problems: relationship to child: \_\_\_\_\_
- learning disability: relationship to child: \_\_\_\_\_
- reading problem: relationship to child: \_\_\_\_\_
- emotional problem: relationship to child: \_\_\_\_\_
- mental retardation: relationship to child: \_\_\_\_\_

8. Please list your concerns regarding your child's communication skills. Explain.

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**Parent signature**

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**Date**

The SLC is a not-for-profit organization and does not discriminate on the basis of race, color or ethnic origin in the administration of its policies. (A limited number of scholarships are available.)