MINNESOTA
MASONIC
CHILDREN'S CLINIC
FOR COMMUNICATION DISORDERS

Formerly the Scottish Rite Clinic for Childhood Language Disorders
24 West 2nd Street
Duluth, MN 55802
218-720-3911

DATE:_____

CASE HISTORY

Please fill out this form as completely as possible, as this information is important in the diagnosis of your child's communication problem. If you need help in completing this form, or have any other questions, please call us at 218-720-3911 and we will be happy to help.

Child's Name_____Date of Birth_____

Street Address_____ Phone_____

City/State_____ Zip_____

Parent's Email:_____

Do you consent to us sharing information using this email address? No Yes ____initial please

Why did you choose our Clinic? (circle one) Quality – Referral – Access – No Cost – Other _____

Please list who lives in the same household with the child:

Name	Age	Relationship	Occupation

Child's Doctor_____ Phone_____

Address_____

What is your child's native language? _____

Who referred you to the Masonic Children's Clinic?_____

Does your child currently receive special services at any other agency? No Yes

Where_____, If possible, please send a copy of a assessment report, current treatment plan, IEP, or IFSP along with this case history form.

Describe your concerns about your child's speech/language development._____

_____

_____

What do you hope to learn from this evaluation?_____

What concerns do you have about your child's hearing?

_____

Has your child ever had his/her ears tested? If yes, please list the date _____

Describe any unusual conditions during pregnancy or birth (illnesses, accidents, medications, etc.)

_____

_____

Length of pregnancy_____ **Child's Birth Weight** _____

Indicate if your child has suffered the following illnesses or conditions:

Allergies**_____ Asthma_____

Colds_____ Ear Infections/Fluid_____

High Fever_____ Influenza_____

Mastoiditis_____ Meningitis_____

Seizures_____ Tonsillitis_____

Other_____

***List allergies*:_____

Is your child taking any medications? No Yes If yes, describe._____

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

Crawl_____ Sit_____ Stand_____

Walk_____ Feed self_____ Dress self_____

Use toilet: day_____ night _____

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

_____

_____

Does your child have unusual responses to sounds, smells, foods in the environment that most children don't react to? No Yes
Describe _____

Does your child respond when his/her name is called? No Yes

Does your child seem to understand your directions? No Yes

Does your child point to things to show them to you? No Yes

Approximately how many words does your child understand?_____

Approximately how many words does your child use?_____

Provide an example of your child's best sentence _____

What does your child like to play with? _____

How would your child communicate in the following situations? Please give an example for each situation.

1. Asking to do something, for instance, to go outside._____
2. Requesting food._____
3. Describing a toy he/she wants._____
4. Wanting to know where mom or dad went._____

Can your child talk about past experiences?_____

Does your child demonstrate in pretend play and imagination (e.g., use a stick to represent a microphone)?

_____

Does your child attend preschool or day care? **No Yes**

Name of facility_____

If your child is school age, provide the name of elementary school your child attends. _____

List five words to describe your child (e.g.,happy, competitive, etc.)_____

_____

Please write/attach any additional information you would like to share with the Masonic Children's Clinic.