



**THE GRUNEWALD-BLITZ CLINIC FOR COMMUNICATION DISORDERS IN CHILDREN**  
**Child Case History Form**  
*(Speech-Language Pathology)*

Please return the completed form to the address or fax above or email it to [SLHSClinic@email.arizona.edu](mailto:SLHSClinic@email.arizona.edu).

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent 1 Name: \_\_\_\_\_ Parent 2 Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Referred by: \_\_\_\_\_ Child's Physician: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

About your family:	Language:
<input type="checkbox"/> Two parents <input type="checkbox"/> Single Parent <input type="checkbox"/> Guardian  Ages of Siblings: _____	Language(s) spoken in the home: _____  Language(s) your child understands: _____  Language(s) your child speaks: _____

What do you want to find out from us?

School: \_\_\_\_\_ Grade: \_\_\_\_\_

My child has (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> IEP or IFSP            | <input type="checkbox"/> Difficulties in school |
| <input type="checkbox"/> Repeated a grade level | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> 504 Plan               |   |

My Child receives the following outside of school (check all that apply):

Occupational Therapy

Behavioral Therapy

Physical Therapy

Counseling

Other:

Describe any complications during pregnancy:

Describe any medical complications at birth or following birth:

Describe any serious illnesses, accidents, or surgery your child has had:

Has anyone else in your family had a speech, language, or hearing problem?

Describe how your child communicates (sounds, words, sentences, etc.):

When was the last time your child's hearing was tested?

Results available?  Yes

No

Comments about your child's hearing:

List any food allergies and restrictions:	List any medications your child takes:

My Child's Strengths	My Child's Needs

Please give any other information you believe will help us understand your child:

Signature of person answering questions

Relationship to child