



Kelly A. Smith, M.S. CCC-SLP  
9910 White Blossom Blvd.  
Louisville, KY 40241  
502-377-6843  
kelly@timetotalk.pro  
www.timetotalk.pro

To All Parents: Please complete this Case History Form prior to your first meeting with Kelly. You may also visit [www.timetotalk.pro](http://www.timetotalk.pro) and complete this case history online. The Case History Form is located on the "For Parents" page.

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Parent/Guardian Name(s)/Contact Information: \_\_\_\_\_

\_\_\_\_\_

Name of Child's School? What is your child's school setting/classroom setting?

\_\_\_\_\_

\_\_\_\_\_

Child's Grade? (if summer, please indicate grade for following school year)

\_\_\_\_\_

\_\_\_\_\_

Please provide any information regarding your child's current services (e.g., PT, OT, Speech, ABA). Please indicate the name of the therapist, location, and number of hours/week child receives services.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Kelly A. Smith, M.S. CCC-SLP  
9910 White Blossom Blvd.  
Louisville, KY 40241  
502-377-6843  
kelly@timetotalk.pro  
www.timetotalk.pro

Please provide a brief description of your child's medical history (hospitalizations, serious illnesses or injuries, frequent ear infections, allergies, seizures, medications, or any other pertinent information). Also, please provide the name of your child's Primary Care Physician and contact information.

---

---

---

---

---

Does your child see any specialists (neurologist, allergist, psychologist, ENT)? Please provide names, contact information, and findings/dates of findings. Please indicate N/A if this section does not apply to your child.

---

---

---

When was the last time your child's hearing was tested? Where was it tested? By whom? What were the results? Do you have any concerns regarding your child's hearing? Did or does your child suffer from frequent ear infections?

---

---

---

---

---

---



Kelly A. Smith, M.S. CCC-SLP  
9910 White Blossom Blvd.  
Louisville, KY 40241  
502-377-6843  
kelly@timetotalk.pro  
www.timetotalk.pro

When was the last time your child's vision was tested? Where was it tested? By whom? What were the results? Do you have any concerns regarding your child's vision?

---

---

---

Do you have any concerns regarding your child's sensory processing? Please explain.

---

---

---

---

Please provide a brief description of your child's prenatal and birth history (i.e., length of pregnancy, complications during pregnancy or delivery, type of birth, length of child's hospital stay).

---

---

---

---

---

Did your child meet his/her developmental milestones within normal limits? At what age did your child crawl? Sit? Walk? Is your child well coordinated? Is your child active?

---

---

---



Kelly A. Smith, M.S. CCC-SLP  
9910 White Blossom Blvd.  
Louisville, KY 40241  
502-377-6843  
kelly@timetotalk.pro  
www.timetotalk.pro

Describe your child's current communication level (verbal, non-verbal, gestures, signs, PECS, number of words, sentences). Is your child intelligible? What is your primary concern?

---

---

---

---

---

---

---

Did your child coo and babble as a baby? Does your child now have a good attention span? What toys/ activities does your child enjoy? Does your child play appropriately with toys? With peers?

---

---

---

---

---

---

---

How well does your child understand what is being said to him or her?

---

---

---

---

---

---

---



Kelly A. Smith, M.S. CCC-SLP  
9910 White Blossom Blvd.  
Louisville, KY 40241  
502-377-6843  
kelly@timetotalk.pro  
www.timetotalk.pro

Does your child enjoy playing with other children and his/her peers? Describe your child's personality.

Does your child have frequent temper tantrums? Does your child have difficulty calming down? Does your child have difficulty following rules?

---

---

---

---

---

---

---

Did your child have difficulty nursing or drinking from a bottle? Any difficulty chewing or swallowing food? When did your child begin to self feed? Does your child eat a variety of foods (crunchy, chewy, mushy, hot, cold)?

---

---

---

---

---

Does your child have difficulty with activities of daily living (toilet training, independent feeding, dressing)?

---

---

---

---

---

---

---

---



Kelly A. Smith, M.S. CCC-SLP  
9910 White Blossom Blvd.  
Louisville, KY 40241  
502-377-6843  
kelly@timetotalk.pro  
www.timetotalk.pro

What are your hopes/expectations for therapy? Would you like Kelly to know any additional information regarding your child?

---

---

---

---

Thank you for taking the time to complete this case history form. Please keep it until your first meeting.

Kelly looks forward to meeting with you!