CASE HISTORY FORM

Person completing this form: _____ Date: _____

Relationship to child: _____

Insurance carrier: _____

Referral Source: _____

PATIENT INFORMATION

Child's name: _____Date of Birth: _____

Address: _____

Male / Female Age: _____ Grade: _____

FAMILY INFORMATION

Mother's name: _____Date of Birth: _____

Occupation: _____ Work phone: _____

Address: _____

Father's name: _____Date of Birth: _____

Occupation: _____Work Phone: _____

Address: _____

Sibling(s): _____ Age: _____

_____ Age: _____

_____ Age: _____

AREA OF CONCERN

Please describe the speech, language, voice, fluency, or learning areas that you are concerned with: _____

_____

_____

_____

_____

_____

When was the problem first noticed? _____

By whom was the problem first noticed? _____

Has your child received any previous help for the areas of concern? **YES / NO** (If yes, please list the type of help, dates of service, and the name of the professional or agency involved.)

1) _____

2) _____

3) _____

4) _____

Name of your child's pediatrician: _____

Address of the pediatrician: _____

FAMILY HISTORY

Are there any family members or relatives who have or have had speech, language, voice, hearing, reading or writing difficulties? **YES / NO** (If yes please provide additional information) _____

_____

_____

_____

_____

Is any language other than English spoken in the home? **YES / NO** (If yes, please list all languages that are spoken) _____

_____

_____

By whom is/are the languages other than English spoken and how frequently? _____

_____

_____

PREGNANCY AND BIRTH HISTORY

Please check all that apply.

Type of Complication	Trimester 1	Trimester 2	Trimester 3
Infection	☐	☐	☐
Fall	☐	☐	☐
Auto Accident	☐	☐	☐
Blood Pressure	☐	☐	☐
X-Rays	☐	☐	☐
Surgeries	☐	☐	☐
Miscarriages	☐	☐	☐
Anemia	☐	☐	☐
Overweight	☐	☐	☐
Spotting	☐	☐	☐
Edema	☐	☐	☐
Hemorrhage	☐	☐	☐
Toxemia	☐	☐	☐
Drugs	☐	☐	☐
Alcohol	☐	☐	☐
Other	☐	☐	☐

Was the baby full term? _____ If not, how early/late? _____

What was the length of labor? _____ Induced? _____ Cesarean? _____

What type of anesthesia? _____ Were forceps used? _____

Baby's weight/length? _____

Were there any complications during delivery? **YES / NO** (If your answer is "yes" please provide further explanation) _____

_____

_____

Did the baby require oxygen? _____ Was he/she jaundiced? _____

Were there any complications immediately following the birth or during the first few weeks of life? :

- ☐ Difficulty Breathing
- ☐ Extended Hospital Stay
- ☐ Difficulty Sucking
- ☐ Jaundice
- ☐ Difficulty Feeding
- ☐ Rubella
- ☐ Other (Please Specify)
- ☐ Seizures
- ☐ Syphilis
- ☐ Birth Defect
- ☐ Sepsis
- ☐ Transfusions
- ☐ Herpes

Additional Comments: _____

_____

_____

_____

DEVELOPMENTAL HISTORY

Please check all that apply to your child:

Behavior	Approximate Age Started
☐ Cried less than normal	_____
☐ Smiled less than normal	_____
☐ Unusual crying sound	_____
☐ Distracted during breast feeding	_____
☐ Yelled/screamed to attract attention	_____

Behavior	Approximate Age Started
☐ Rocking or banging of head	_____
☐ Generally indifferent to sound	_____
☐ Difficulty sucking	_____
☐ Difficulty chewing	_____
☐ Difficulty swallowing	_____
☐ Preferred foods	_____
☐ Excessive drooling	_____
☐ Other:	_____

At what age did the following occur? (Please give your closest time approximation)

Held head up _____

Rolled over back to stomach _____

Sat unsupported _____

Crawled _____

Walked unassisted _____

FEEDING BEHAVIORS

Has your child had any of the following feeding difficulties?

☐ Sucking or nursing

☐ Choking and / or gagging

☐ Weaned from bottle

☐ Ate from spoon

☐ Excessive time to drink bottle

☐ Drank from an open cup

☐ Ate lumpy/chopped food

☐ Ate meat/solids

☐ Difficulty chewing or swallowing meat

☐ Regurgitation of liquids or solids through nose

Does your child choke while eating? **YES / NO** (If "yes", on which foods?) _____

_____

_____

Is your child a picky eater? **YES / NO** (If "yes", what foods does he / she prefer?) _____

_____

_____

Describe any feeding problems your baby experienced during the first 3 months of life.

_____

_____

_____

_____

Does your child drool more than other children his / her age? **YES / NO**

Did your child have difficulty gaining weight as an infant? **YES / NO**

EXPRESSIVE & RECEPTIVE MILESTONES

At what age did the following occur (please provide approximate age-years/mos.)?

Respond to own name _____

Followed simple directions _____

Recognized names of familiar objects _____

Pointed to eyes, nose, and mouth when named _____

Babbled _____

Said first word _____

Had a vocabulary of 10 words _____

Combined two-words _____

Talked in short sentences _____

Said full name _____

Verbally related events/experiences _____

Additional info/explanation: _____

_____

_____

_____

Please answer the following at the present time:

Does your child follow directions correctly? **YES / NO** (If your answer is "no" please provide further explanation of what your child does in place of this behavior)

_____

_____

Does your child respond to questions appropriately? **YES / NO** (If your answer is "no" please provide further explanation of what your child does in place of this behavior)

_____

_____

Do you need to use gestures? **YES / NO** (If your answer is "yes" please provide further explanation of what your child does in place of this behavior)

_____

_____

Do you need to repeat? **YES / NO** (If your answer is "yes" please provide further explanation of what your child does in place of this behavior)

_____

_____

Do you need to speak in short sentences? **YES / NO** (If your answer is "yes" please provide further explanation of what your child does in place of this behavior)

_____

_____

_____

How does your child communicate his/her wants and needs?

_____

_____

_____

How much of your child's speech do you understand?

10% 25% 50% 75% 100%

How much of your child's speech do unfamiliar listeners understand?

10% 25% 50% 75% 100%

Does a parent need to interpret for others? **YES / NO** (If your answer is "yes" please provide further explanation)

_____

_____

Does your child grope for words or use the wrong word? **YES / NO** (If your answer is "yes" please provide further explanation of his/her behavior)

_____

_____

Does your child repeat sounds or words previously heard? **YES / NO** (If your answer is "yes" please provide further explanation of his/her behavior)

_____

_____

Does your child's voice have a nasal or harsh quality? **YES / NO** (If your answer is "yes" please provide further explanation of his/her behavior)

_____

_____

Does your child seem to have adequate hearing? **YES / NO** (If your answer is "no" please provide further explanation of his/her behavior)

_____

_____

Has your child's hearing ever been tested? **YES / NO** If so where? _____

When? _____ Results of test: _____

MEDICAL HISTORY

(Please indicate age of occurrence on the adjacent line)

☐ Adenoidectomy_____ ☐ Allergies _____ ☐ Asthma_____

☐ Blood disease_____ ☐ Chicken pox_____ ☐ Croup_____

☐ Dental problems _____ ☐ Diphtheria_____ ☐ Earaches_____

☐ Ear infections_____ ☐ Encephalitis_____ ☐ Eye problems_____

☐ Headaches_____ ☐ Head injury_____ ☐ Heart Problems_____

☐ High fevers_____ ☐ Influenza_____ ☐ Measles_____

☐ Meningitis_____ ☐ Mumps_____ ☐ Muscle disorder_____

☐ Nerve disorder_____ ☐ Orthodontia_____ ☐ Pneumonia_____

☐ Rheumatic fever _____ ☐ Polio_____ ☐ Seizures_____

☐ Scarlet fever_____ ☐ Tonsillectomy_____ ☐ Tonsillitis_____

☐ Tuberculosis_____ ☐ Whooping cough_____

Please describe any other serious illnesses, injuries or physical problems not mentioned above: _____

_____

_____

_____

Does your child have any allergies? **YES / NO** (If your answer is "yes" please list all allergies)

_____

_____

Does your child take any medications? **YES / NO** (If your answer is "yes" please list all medications) _____

_____

Has your child ever been hospitalized? **YES / NO** (If your answer is "yes" please provide further explanation) _____

_____

_____

SOCIAL / EMOTIONAL DEVELOPMENT

Please check all behaviors that you feel best describe your child:

- ☐ Overly active
- ☐ Overly quiet
- ☐ Destructive
- ☐ Perfectionist
- ☐ Outgoing
- ☐ Prefers older children
- ☐ Happy
- ☐ Defiant
- ☐ Easily controlled/passive
- ☐ Very shy
- ☐ Friendly
- ☐ Plays well with other children
- ☐ Anxious
- ☐ Stubborn
- ☐ Prefers younger children
- ☐ Difficulty separating from parents

SOCIAL BEHAVIOR

Which of the following describes the type of play your child likes to engage in most often?

- ☐ Putting toys in mouth
- ☐ Uses one object for another
- ☐ Does role playing
- ☐ Rough & tumble play
- ☐ Shaking toys
- ☐ Throwing toys
- ☐ Games with rules
- ☐ Make believe play
- ☐ Banging toys together
- ☐ Pushing/pulling toys
- ☐ Acts out familiar routines
- ☐ Appropriate use of objects

What is the average length of time your child can stay playing at one activity?

_____

_____

What activities seem to hold your child's attention for the shortest period of time?

_____

_____

What activities seem to hold your child's attention for the longest period of time?

_____

_____

How does your child relate to you? _____

To your spouse? _____

To other children? _____

What is/are your child's preferred play activities?

_____

_____

Does your child avoid any play activities? **YES / NO** (If your answer is "yes" please provide further explanation of his/her behavior) _____

_____

_____

Is your child toilet trained? **YES / NO**

EDUCATIONAL HISTORY

Name of school your child is attending? _____

Name of his/her present teacher(s)? _____

Grade: _____ Full time? **YES / NO** (If your answer is "no" please list any other school(s) or daycare he/she attends, as well as how often) _____

_____

_____

What are your child's best subjects? _____

_____

Worst subjects? _____

Does your child receive services from school? **YES / NO** (If yes please provide how often and by whom) _____

_____

_____

In scheduling your child's evaluation or therapy, is there any need for handicapped accessibility? _____

_____

Other pertinent information or comments: _____

_____

_____

_____

Please provide copies of any pertinent assessments, reports, and/or records prior to your child's first appointment. THANK YOU!