



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, feeding, 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	1st Trimester	2nd Trimester	3rd Trimester
Infectious/communicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auto accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overweight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spotting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Edema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toxemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Difficulty Sucking | <input type="checkbox"/> Difficulty Feeding |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Extended Hospital Stay | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rubella Herpes |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Sepsis | <input type="checkbox"/> Other (Please Specify) |

Additional Comments:

DEVELOPMENTAL HISTORY

Please check all that apply to your child:

<u>Behavior</u>	<u>Yes</u>	<u>No</u>	<u>Approximate age the behavior started</u>	<u>Additional explanations</u>
Cried less than normal	<input type="checkbox"/>	<input type="checkbox"/>		
Smiled less than normal	<input type="checkbox"/>	<input type="checkbox"/>		
Unusual crying sound	<input type="checkbox"/>	<input type="checkbox"/>		
Distracted during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>		
Yelled/screamed to attract attention	<input type="checkbox"/>	<input type="checkbox"/>		
Rocking or banging of head	<input type="checkbox"/>	<input type="checkbox"/>		
Generally indifferent to sound	<input type="checkbox"/>	<input type="checkbox"/>		
Difficulty sucking	<input type="checkbox"/>	<input type="checkbox"/>		
Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>		
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>		
Preferred foods	<input type="checkbox"/>	<input type="checkbox"/>		
Excessive drooling	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>		

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

Held head up	_____	Weaned from bottle	_____
Rolled over back to stomach	_____	Ate from spoon	_____
Sat unsupported	_____	Drank from an open cup	_____
Crawled	_____	Ate lumpy/chopped food	_____
Walked unassisted	_____	Ate meat/solids	_____

FEEDING BEHAVIORS

Has your child had any feeding difficulties?

- | | |
|--|---|
| <input type="checkbox"/> Sucking or nursing | <input type="checkbox"/> Difficulty chewing or swallowing meats |
| <input type="checkbox"/> Choking and / or gagging | <input type="checkbox"/> Excessive length of time to drink bottle |
| <input type="checkbox"/> Regurgitation of liquids or solids through the 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**

At what age did the following occur?

<u>Expressive and Receptive milestones</u>	<u>Age</u>	<u>Additional info/explanation</u>
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		

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

<input type="checkbox"/> Adenoidectomy	Age _____	<input type="checkbox"/> High fevers	Age _____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Influenza	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Blood disease	_____	<input type="checkbox"/> Meningitis	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Seizures	_____	<input type="checkbox"/> Muscle disorder	_____
<input type="checkbox"/> Croup	_____	<input type="checkbox"/> Nerve disorder	_____
<input type="checkbox"/> Dental problems	_____	<input type="checkbox"/> Orthodontia	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Earaches	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Ear infections	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Eye problems	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Headaches	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Head injury	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Heart Problems	_____	<input type="checkbox"/> 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:

- | | |
|---|---|
| <input type="checkbox"/> Overly active | <input type="checkbox"/> Defiant |
| <input type="checkbox"/> Overly quiet | <input type="checkbox"/> Easily controlled/passive |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Very shy |
| <input type="checkbox"/> Perfectionist | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Plays well with other children |
| <input type="checkbox"/> Prefers older children | <input type="checkbox"/> Prefers younger children |
| <input type="checkbox"/> Difficulty separating from parents | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Stubborn |

SOCIAL BEHAVIOR

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Putting toys in mouth | <input type="checkbox"/> Shaking toys | <input type="checkbox"/> Banging toys together |
| <input type="checkbox"/> Uses one object for another | <input type="checkbox"/> Throwing toys | <input type="checkbox"/> Pushing / Pulling toys |
| <input type="checkbox"/> Does role playing | <input type="checkbox"/> Games with rules | <input type="checkbox"/> Acts out familiar routines |
| <input type="checkbox"/> Rough & tumble play | <input type="checkbox"/> Make believe play | <input type="checkbox"/> 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!**