Case History Information

Name:		**Social Security Number:**	
Date of Birth:		**Sex:**	
Address:		**Date Case History completed:**	
	#, Street, Apt#/ P.O. Box	**Completed by:**	
		Relationship to child:	
	City, State, Zip		

Physician's Office:	Name of office:		Physician's Name:	
	Address:		Phone:	
		#, Street, Apt#/ P.O. Box	Fax:	
		City, State, Zip		

Primary Insurance:	Insurance Name:		**Secondary Insurance:**	Insurance Name:	
	Policy #:			Policy #:	
	Group #:			Group #:	
	Insured Name:			Insured Name:	
	Date of Birth:			Date of Birth:	
	Employer:			Employer:	
	Employer Phone #:			Employer Phone #:	

FAMILY INFORMATION:

Mother's Name:			**Father's Name:**		
Mother's Date of Birth:			**Father's Date of Birth:**		
Phone Numbers:	**Cell:**	**Home:**	**Phone Numbers:**	**Cell:**	**Home:**
Mother's Home Address:			**Father's Home Address:**		
	#, Street, Apt#/ P.O. Box			#, Street, Apt#/ P.O. Box	
	City, State, Zip			City, State, Zip	
Email Address:			**Email Address:**		
Mother's Employment:	Occupation: Company:		**Father's Employment:**	Occupation: Company:	
	#, Street, Apt#/ P.O. Box			#, Street, Apt#/ P.O. Box	
	City, State, Zip			City, State, Zip	

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Please list brothers and sisters of child:

Name	Age	Sex	Speech, Hearing, or Medical Problems
1.			
2.			
3.			
4.			
5.			

List any relatives of the child closer than second cousin who have or had a hearing loss, speech language problem, learning disability, or any other physical disability. Indicate the cause if known:

Name	Relationship	Type of Problem & Cause
1.		
2.		
3.		
4.		
5.		

BACKGROUND INFORMATION:

Please describe your concerns:

_____
_____
_____
_____

What are your goals for your child? _____
_____
_____

When was the problem first noticed: _____By whom? _____

What do you think caused the problem? _____

What changes in your child's speech-language or hearing have you noticed since that time? _____
_____
_____

Please list the persons/ clinic that you have contacted about the problem:

Date	Name/ Clinic	What were you told about the problem?

Does your child have a specific diagnosis? _____

When was the diagnosis made? _____By whom? _____

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PREGNANCY/ BIRTH HISTORY:

Please explain any pertinent information regarding the pregnancy/ birth of your child that may aid in the evaluation:

_____
_____
_____
_____

During the pregnancy, did the mother experience any of the following conditions (Please check if **YES**):

- ❑ Excessive Vomiting
- ❑ Bleeding
- ❑ Swelling
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ High Fevers
- ❑ Convulsions
- ❑ Excessive Weight Gain or Loss
- ❑ Virus Infection (Rubella)
- ❑ Asthma
- ❑ Kidney Disease
- ❑ X-Rays
- ❑ Rh- Negative
- ❑ Decreased Amniotic Fluid
- ❑ Smoking
- ❑ Gestational Diabetes
- ❑ Drug Use
- ❑ Hallucinogens
- ❑ Toxemia
- ❑ Surgery
- ❑ Medications- Please list ⇨
- ❑ Other- Please specify⇨

What was the length of pregnancy? _____ weeks.

Type of delivery: (please check):

- ❑ Vertex (head presentation)
- ❑ Planned Cesarean/ Reason: _____
- ❑ Emergency Cesarean Section/ Reason: _____
- ❑ Breech
- ❑ Dry
- ❑ Other: _____

Were there any unusual problems at birth?_____ If so, please describe: _____

_____
_____

Birth Weight: _____ Length:_____

Apgar score at 1 minute: _____ At 5 minutes: _____

Were there health problems during the first 2 weeks of the infant's life? _____

_____
_____

How long did the child remain in the hospital nursery? _____

Please check if YES and explain below:

- ❑ Jaundice
- ❑ Difficulty with Breathing
- ❑ Convulsions
- ❑ Incubator or Isolette
- ❑ Seizures
- ❑ Infection
- ❑ Congenital deformity
- ❑ Surgery
- ❑ Transfusion
- ❑ Breathing tube
- ❑ Tube fed
- ❑ Medications
- ❑ Hemorrhage
- ❑ Feeding difficulties
- ❑ Oxygen
- ❑ Intravenous Fluids

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MEDICAL HISTORY:

Please list the medications your child takes: For what reason?

Please list your child's allergies below:

Has your child ever been hospitalized? _____ When? _____ For how long? _____
Reason?_____ Where?_____
_____
_____
_____

Describe any operations your child has had, if any: _____
_____
_____

Has your child had any of the following? **Please give dates and indicate whether the child had the illness or was immunized.**

	No	**Yes/ Date**	**Remarks**
Diabetes			
Lung Difficulties			
Heart Defect			
Seizures			
Cleft Palate/ Cleft Lip			
Ear Infections			
High Fevers			
Meningitis			
Allergies			
Physical Injuries			
Has you child been exposed to the HIV Virus?			
Has your child been exposed to Tuberculosis (TB)?			
Chicken Pox			
Influenza			
Asthma			
Tonsillitis			
Mumps			
Measles			
Chronic Colds			
Croup			
Pneumonia			
Headaches			
Epilepsy			
Encephalitis			
Tonsillectomy (tonsils removed)			
Adenoidectomy (adenoids removed)			
Other			

Case History Information

Hearing:

Do you think your child hears adequately? _____

Has your child's hearing been examined? _____ Date:_____ By whom?_____
Results: _____

Has your child had chronic ear infections (3 or more in one year)?_____When? _____

Has your child's eardrum ever ruptured?_____ Which ear/ ears?_____When? _____

Has your child ever had tubes placed in his ears?_____ Which ear/ ears?_____When? _____

Has your child had an ear infection within 3 months prior to this evaluation?_____

Does your child wear hearing aids? _____ if so, which ear/s?_____What kind?_____

When did he/s he begin using aids? _____ Does amplification help him/ her?_____

Vision:

Does your child wear glasses?_____ Since when? _____
Have your child's eyes been examined? _____ Date_____ By whom?_____
Results: _____

EDUCATIONAL HISTORY:

School/Daycare: _____Grade: _____ Teachers: _____

Does your child receive learning support, special education etc.?_____
_____
Receiving SLT, OT, PT (times per week and minutes per session): _____
_____

Therapist's Name: _____Telephone#: _____
Therapist's Name: _____Telephone#: _____
Therapist's Name: _____Telephone#: _____

PHYSICAL DEVELOPMENT:

Note the ages in months when the following occurred:

_____Held head erect	_____Pulled self to sit
_____Rolled from back to stomach	_____Stood unsupported
_____Played with hands	_____Pulled self to stand
_____Reached for objects	_____Walked alone
_____Crawled	_____Fed self with spoon
_____Sat unsupported	_____Tied shoes
_____Toilet trained	_____Dressed self

Does child lose balance or fall easily?_____

Does your child have aversion to loud sounds? _____

Does your child have aversion to different textures? _____ (ie: water during bathing/ sand/ mess on hands)

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SOCIAL AND BEHAVIORAL HISTORY:

Have there been any changes that might have been stressful for your child (past and/or present, e.g., hospitalization, death of someone close, numerous moves, separations, divorce)?_____

Does your child tend to play alone or with other children?_____

Age of playmates:_____

How does your child get along with other children?_____

With adults?_____

Is it difficult to discipline your child? (Explain as fully as possible.)_____
_____
_____
_____

Would you describe your child as happy or unhappy?_____

Is your child unusually quiet?_____Unusually active?_____

Does your child have difficulty in concentrating?_____

Difficulty sleeping?_____

Does anything else about your child's behavior concern your?_____

If so, please describe:_____

What are your child's favorite play activities?_____

How does your child feel about school and about his/her teachers?_____

How does your child get along with his/her bothers and sisters? (e.g. enjoys their company, argues or fights frequently, play cooperatively, etc._____

Does your child have any fears that you consider excessive or which concern you? _____

Does your child have frequent nightmares?_____

Does your child have temper tantrums?_____How often?_____

Case History Information

SPEECH LANGUAGE DEVELOPMENTAL HISTORY:

What language is primarily spoken at home?_____

Please note at **what age** (in months) your child first used the following skills:

• At what age did infant babble and coo?		• At what age did he/ she have a vocabulary of 5 words?	
• At what age did child respond to his/her name?		• At what age did child wave hi/ bye?	
• When did your child use gestures (shaking head/ pointing) to communicate?		• When did your child say his/her first word?	
• At what age could child identify objects by pointing?		• When did your child put 2 words together to form a phrase (more cookie/ want ball)?	
• At what age did child follow simple directions, such as "Give it to Mommy"?		• When did your child use 3 to 4 word sentences?	

Does your child communicate most by: (check all that apply)

__ pointing __ sign language __ complete sentences
__ sounds __ single words __ leading adult to desired object
__ gestures __short 2-3 word phrases

Did your child acquire speech words and than gradually lose the words?

__Yes __ No If yes, approximate age___

Does your child repeat what others say or previously heard script (recite movie scenes/ echolalia)?_____

Does your child understand: _____words _____phrases _____sentences _____ gestures

Does your child understand and follow:

_____Simple commands (i.e., Give me the ball)
_____Longer commands (i.e., Pick up the ball and go put it away in your toy box)

How well can your child be understood: by parents in a known context/ situation_____% (please give percentage)
by parents in an unknown context/ situation_____% (please give percentage)
by other adults_____%(please give percentage)

What sounds does your child have difficulty saying? _____
_____
_____

Does your child get stuck and/ or repeat sounds? _____ Please explain: _____
_____

Does your child's voice seem normal to you? _____ If, it is unusual, please describe: _____
_____

Has your child received speech language therapy previously? _____ Please describe: _____
_____
_____
_____
_____

Case History Information

FEEDING HISTORY:

Has your child had any feeding difficulties?_____

Does your child eat a variety of textures? (For example: crunchy cookies, applesauce, yogurt with pieces)? _____
If no, explain: _____
_____
_____

What does your child drink out of? _____bottle _____open cup _____sippy cup _____straw

At what age did your child first finger feed him/ herself?_____

At what age did your child first spoon feed him/ herself?_____

At what age did your child first drink from a cup?_____

Did your child have trouble sucking and/or nursing?_____

If your child still bottle feeds, does he/ she take an excessive length of time to drink a bottle?_____

Regurgitation of liquids or solids through the nose?_____

Difficulty chewing meats?_____

Choking and/or gagging?_____

Has your child ever had a swallow study?_____ if yes, please explain: _____
_____

If there is any other information you think will help us to evaluate your child, please explain here.

Thank you for your help. Your insights will enable me to do my best for you and your child.