Case History

Child & Family Information: Today's Date: ___________________________

Child's Name: ____ Age: _______

Nickname: ___________________________________ Date of Birth: ____________________________

Address:____

City: ______________________________ State: ___________ Zip Code: __________________

School: ____ Grade: _______

Parents' Names: ____

Sibling(s): ____ Age(s): ____________________

Other relatives or persons living in the household: ____

Mother's Occupation: ____________________________ Work phone: _____________________

Father's Occupation: _____________________________ Work phone: _____________________

Mother's Cell Phone: ______________________ Father's Cell Phone: ______________________

Email address: ____

Primary language spoken in the home: _________________ Additional languages: _______________

Family history of speech, language, or feeding difficulties: yes no

If yes, please describe: ____

Pediatrician: ____ Phone number: ____________________

Who were you referred by or how did you hear about us: ____

Birth History:

Please list any pregnancy complications: ____

Please list any medications taken during pregnancy: ____

Length of pregnancy: _______________ Birth Weight: _______________ Apgar Scores: _______________

Please list any birth complications: ____

Labor: Normal Induced C-Section

Please list any birth complications: ____

Medical History:

Existing Diagnoses: ____

Does your child have a history of any of the following childhood illnesses or disorders? If so, please circle Y and give the number of occurrences if greater than one.

Ear Infection: Y N ___________ Ear tubes: Y N ___________

Cold: Y N ___________ Fever: Y N ___________

Pneumonia: Y N ___________ Strep Throat: Y N ___________

Chicken Pox: Y N ___________ Asthma: Y N ___________

Seizures: Y N ___________

Other: ____

Please list any allergies your child has: ____

Please list all previous and current medications: ____

Please list all surgeries: ____

Please list and describe any hospitalizations: ____

Has your child's vision been formally tested? Y N Results: ___________________________

Has your child's hearing been formally tested? Y N Results: ___________________________

Developmental History: (please give an approximate age)

Sitting up unsupported: ____________________ Crawling: ________________________________

Standing: _________________________________ Walking: ________________________________

Babbling: _________________________________ First word: _______________________________

Imitating words: ___________________________ Combining words: _________________________

What are your concerns regarding your child's speech and language development?

____

____

Does your child seem to:

understand what you are saying to him/her? Y N

follow multiple step directions? Y N

easily imitate new sounds and words? Y N

effectively communicate his/her wants and needs? Y N

respond to his/her name? Y N

look at you when you are talking? Y N

Feeding History:

Was your child breast fed? Y N Age when child weaned: ___________________

Bottle fed? Y N How long? ______________________________

Please give the approximate age for the following:

Sippy Cup: _________________ Open cup: _________________ Straw: ______________

Pureed Food: ____________________ Table food: ____________________

Please list any concerns you may have about your child's feeding development:

____

____

Treatment History:

Please list any additional therapies (speech and language, occupational, physical, vision, etc…) your child is currently receiving or has received in the past. Please give the dates of treatment as well.

____

If you were referred for speech, language or feeding therapy by a physician, please list additional therapies recommended: ____

Thank you