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www.speechhearing.org

Pediatric Case History Form

Speech Language Pathology

Please fill out this form as completely as possible. This information is crucial for our evaluation process; your input gives us insight into your child's everyday level of functioning. Please try to give additional comments where appropriate.

**Please note*: Once you have completed this form, please return it to our office, along with any other pertinent academic or medical information, such as an IEP or report from other therapists.

Date completed: _____

I: Case Information

Child's Name: _____ (Nick name or goes by: _____)

Child's Date of Birth: _____ Age: _____ Sex: _____ Grade in school: _____

Father's Name: _____
Date of Birth: _____
Father's Address: _____
_____
Father's Employer: _____
Position: _____
Father's Telephone: (H) _____
(W) _____
(C) _____
Email: _____*

Mother's name: _____
Date of Birth: _____
Mother's Address: _____
_____
Mother's Employer: _____
Position: _____
Mother's Telephone: (H) _____
(W) _____
(C) _____
Email: _____*

***Best contact Email for follow up conversations and waitlist confirmation: Father Mother**

Parents' marital status: S M D W

Parents are remarried: Mother Father

Child Lives with: ☐ Birth Parents ☐ Foster Parents ☐ One Parent ☐ Adoptive Parents
☐ Parent and Step-parent ☐ Other: _____

Primary Language(s) spoken by **child**: _____
Primary Language(s) spoken by **caregivers: _____** Other Languages spoken in home: _____

.....

Primary Insurance: _____ Phone: _____

Address: _____ ID#: _____

Card Holder Name: _____ Card Holder DOB: _____

Secondary Insurance: _____ Phone: _____

Address: _____ ID#: _____

Card Holder Name: _____ Card Holder DOB: _____

Speech Therapy sessions are 30 minutes in duration. Please indicate your availability for attending therapy sessions by drawing Xs in the time slots for which you would be able to attend regular weekly sessions. . Keep in mind Mornings and Early Afternoons slots open more frequently then afternoon slots. Evaluations are different then the regular session times and can be scheduled for anytime that a Therapist has an opening. The 3-4pm wait list is for younger school age children (First Grade and up) and the 4-6 range is for older children (Middle and High school) due to full day school dismal times.

Childs Name: _____ DOB: _____

	M	T	W	TH	F	SAT
8:00-8: 30						
8: 30-9:00						
9:00-9: 30						
9: 30-10:00						
10:00-10: 30						
10: 30-11:00						
11:00-11: 30						
11: 30-12:00						
12:00-12: 30						
12: 30-1:00						
1:00-1: 30						
1: 30-2:00						
2:00-2: 30						
2: 30-3:00						
3:00-3: 30						
3: 30-4:00						
4:00-4: 30						
4: 30-5:00						
5:00-5: 30						
5: 30-6:00						

Please describe why you are having your child seen for a speech language evaluation:

Articulation (making the speech sounds accurately): ☐ _____
Stuttering (repeated sounds, syllables, words): ☐ _____
Language Delay (difficulty understanding or speaking): ☐ _____
Voice (hoarse, strained): ☐ _____
Reading/Writing difficulties (letter names/sounds): ☐ _____
Additional: ☐ _____

How did you hear about us?

☐ Word of mouth ☐ Newspaper/magazine ☐ School system
☐ Internet ☐ physical/pediatrician ☐ other _____

II: <u>Family History</u>

1. Please list names and ages of everyone living in the home:

Name Age Relationship

_____
_____
_____
_____
_____

2. Is this child adopted? _____ At what age? _____ Does the child know? _____
3. Are there any incidences of any of the following conditions among the **child's immediate family or close relatives?** Please check any/all that apply and explain.
   ☐ Speech delay/difficulties_____
   ☐ Hearing difficulties _____
   ☐ Learning difficulties _____
   ☐ Seizures/convulsions _____
   ☐ Intellectual Impairment _____
   ☐ Heart disease _____
   ☐ Autism or Down syndrome _____

III: <u>Birth History</u>

1. During pregnancy, did the mother:	Yes	No
» Contract any diseases?	☐ _____	☐
» Take any prescriptions of any kind?	☐ _____	☐
» Suffer any accidents/falls?	☐ _____	☐
» Become exposed to x-ray treatments?	☐ _____	☐
» Present with Rh incompatibility?	☐ _____	☐
» Undergo amniocentesis (genetic testing)?	☐ _____	☐
» Suffer any emotional stress?	☐ _____	☐
» Become exposed to rubella?	☐ _____	☐
» Consume alcohol?	☐ _____	☐

2. Labor & Delivery
   - » Length of labor: _____ Labor was: ☐ Spontaneous ☐ Induced
   - » Baby was delivered: ☐ Full Term ☐ Premature at _____ weeks
     - Delivery via: ☐ Cesarean ☐ Vaginal ☐ Breech
   - » This was a: ☐ single birth ☐ Multiple birth _____
   - » Were instruments used to assist with birth? ☐ Yes ☐ No
   - » Were any drugs administered? ☐ Yes ☐ No
     Please list drugs given and purpose, as explained to you: _____ _____ _____
   - » Was baby pronounced healthy at birth? ☐ Yes ☐ No
   - » Weight at delivery: _____
   - » Apgar scores, if known: _____
   - » Please indicate Yes or No for the following: Comments
     - Breathing difficulties at birth? ☐ Yes ☐ No _____
     - Described as "blue baby"? ☐ Yes ☐ No _____
     - Jaundiced? ☐ Yes ☐ No _____
     - Placed on feeding tube? ☐ Yes ☐ No _____
     - Discharged separately from mom? ☐ Yes ☐ No _____
   - » Did the child experience any early feeding/swallowing problems? ☐ Yes ☐ No _____

IV. <u>Medical History</u>

1. Child's pediatrician/family doctor: _____
   Address: _____
2. List any medications your child is currently taking regularly and include purpose:_____ _____ _____
3. Is your child currently under a physician's care: ☐ Yes ☐ No Why:_____
4. Does your child have any known allergies: ☐ Yes ☐ No List: _____ _____ _____
5. Has your child been exposed to nuts? ☐ Yes ☐ No
6. Is your child's immunization record up to date? ☐ Yes ☐ No
7. Does your child have any **medical or educational diagnoses**? (e.g., Autism, ADD, PDD) ☐ Yes ☐ No
   - » IF YES: DIAGNOSIS PHYSICIAN/PROFESSIONAL who assigned diagnosis
     _____ _____
     _____ _____
     _____ _____

8. ENT & Upper respiratory: Does the child have a history of:

			Comments
» Ear infections	☐ Yes	☐ No	_____
» PE tubes	☐ Yes	☐ No	_____
» Drainage from ear	☐ Yes	☐ No	_____
» Frequent colds or sinus infections	☐ Yes	☐ No	_____
» Tonsils/adenoids removed	☐ Yes	☐ No	_____
» Bronchitis or pneumonia	☐ Yes	☐ No	_____
» Asthma or other breathing difficulties	☐ Yes	☐ No	_____

9. Medical conditions: Does your child have a history of:

			Comments
» High fevers lasting longer than 1 day	☐ Yes	☐ No	_____
» Seizures	☐ Yes	☐ No	_____
» TB, Meningitis, Diphtheria	☐ Yes	☐ No	_____
» Chicken Pox, Measles, Mumps	☐ Yes	☐ No	_____
» Heart condition(s)	☐ Yes	☐ No	_____
» Anemia	☐ Yes	☐ No	_____
» Encephalitis	☐ Yes	☐ No	_____

10. Hospitalizations/Surgeries: Please list and provide dates:

Illness/Procedure	Date
_____	_____
_____	_____
_____	_____

11. Current physicals/test:

	Date		Results/Comments
» Most recent physical exam:	_____		_____
» Most recent hearing test:	_____		_____
• Does child wear a hearing device?	☐ Yes	☐ No	_____
» Most recent vision test:	_____		_____
• Does child wear glasses?	☐ Yes	☐ No	_____

V. <u>Speech & Language Development</u>

1. Did your child cry normally? (To communicate discomfort, fear, loneliness, etc.) ☐ Yes ☐ No
2. Did your child:

			If NO, age began:
» Coo or babble by age 4 months	☐ Yes	☐ No	_____
» Respond to name or social games like Peek-a-boo by 8 months	☐ Yes	☐ No	_____
» Use jargon* by 12 months	☐ Yes	☐ No	_____
» Imitate sounds by 12 months	☐ Yes	☐ No	_____
» Say first word by 15 months	☐ Yes	☐ No	_____
» Say 2 words together by 24 months	☐ Yes	☐ No	_____
» Use short sentences by 36 months	☐ Yes	☐ Yes	_____

**Jargon is defined as words that are not understandable, but consist of adult-like intonation patters and are spoken in "sentences".*

3. Has speech/language development ever been **interrupted**? ☐ Yes ☐ No

_____
_____
_____

4. Has speech/language development changed in the last **6 months**? ☐ Yes ☐ No _____

5. How does your child communicate with you? ☐ Words ☐ Points ☐ Other _____ ☐ Grunts ☐ Cries _____ ☐ Gestures ☐ AAC _____

6. How does your child communicate with siblings and/or peers? ☐ Words ☐ Points ☐ Other _____ ☐ Grunts ☐ Cries _____ ☐ Gestures ☐ AAC _____

7. Please give at least 2 examples of your child's comments that are typical at this time: _____

8. Please indicate any which are difficult for your child:
   - ☐ Eating a variety of foods
   - ☐ Using a straw
   - ☐ Blowing bubbles or on a pinwheel
   - ☐ Following directions or routines
   - ☐ Understanding what he/she hears
   - ☐ Understanding concepts of time
   - ☐ Pronouncing sounds/words correctly
   - ☐ Stating the *sounds* letters make
   - ☐ Rhyming
   - ☐ Singing songs/nursery rhymes
   - ☐ Labeling things, identifying "what is it"
   - ☐ Speaking in organized sentences
   - ☐ Answering questions
   - ☐ Telling stories, recalling events
   - ☐ Recognizing common words (sight words)
   - ☐ Writing his/her name, letter sizing or formation
   - ☐ Self-calming
   - ☐ Receiving or giving hugs
   - ☐ Hand-eye coordination
   - ☐ Keeping shoes on
   - ☐ Keeping hands to him/herself

VI. Educational History

1. Name of school / daycare: _____
   Address: _____

   Child's schedule: Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____

   Current Grade: _____
   Current name of: Teacher: _____
   Special Ed. Teacher: _____
   Speech Therapist: _____
   Other professional: _____

2. Has your child been held back at any grade level? ☐ Yes ☐ No Grade: _____ Reason: _____

3. Does your child have an IEP? ☐ Yes* ☐ No *Please provide a copy
4. Is your child currently receiving Special Edu. Services through the school system? ☐ Yes ☐ No
   - » What is the **disability code**? _____
   - » Type and amount of service received? _____
5. Please describe your child's attitude toward school: _____

VII. <u>Motor Development History</u>

1. Did your child:

Hold his head up by 4 months	☐ Yes	☐ No	First sit unassisted by 12 months	☐ Yes	☐ No
First crawl by 12 months	☐ Yes	☐ No	First walk alone by 16 months	☐ Yes	☐ No
First ate solid food by 12 months	☐ Yes	☐ No	Fed self by 2 years	☐ Yes	☐ No
First used scissors by 3 years	☐ Yes	☐ No	Thumb & finger grasp of crayon/pencil	☐ Yes	☐ No

2. Please describe your child's gross motor skills while walking, running, etc. _____ _____ _____
3. Please describe your child's fine motor skills while coloring, self-feeding, etc. _____ _____ _____
4. Child's handedness: ☐ Right ☐ Left ☐ uses Both equally ☐ _____

VIII. <u>Behavioral History</u>

Please check all that describe your child.

☐ Friendly	☐ Impulsive	☐ Separation difficulties	☐ Difficulty sleeping
☐ Easy-going	☐ Cooperative	☐ Poor Eye contact	☐ Plays well with others
☐ Hyperactive	☐ Attentive	☐ Aggressive	☐ Doesn't like to be read to
☐ Defiant	☐ Poor memory	☐ Has temper tantrums	☐ Willing to try to activities
☐ Sleeps well	☐ Unpredictable	☐ Eats well	☐ Will not eat certain textures
☐ Bites nails	☐ Stubborn	☐ Uses pacifier/sucks thumb	☐ Very emotionally sensitive
☐ Talkative	☐ Clumsy	☐ Difficulty transitioning	☐ Doesn't like to be touched
☐ Shy, quiet	☐ withdrawn	☐ Short attention span	☐ Sensitive to lights, sounds

IX. <u>Other Evaluations and Services</u> (Please provide copies.)

1. Date of most recent EDUCATIONAL evaluation: _____
   Date of most recent PSYCHOLOGICAL evaluation: _____
   Date of most recent SPEECH-LANGUAGE evaluation: _____
2. Please complete the following for professionals **currently working with your child:**

Type of Service	Name of provider	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Please complete the following for professions who have w**orked with your child in the past:**

Type of Service	Dates	Why Terminated
_____	_____	_____
_____	_____	_____

X. Tell us about your child

1. Does your child have hobbies? _____
   _____
2. With whom does your child like to play? _____
3. About how much TV in the week? What type of shows? _____
4. Play any sports? _____
5. Do you having reading time? How often? What type of books? _____
6. How much playtime together? _____

Additional information

Please provide any other information which would be helpful in us getting to know your child and assist with his or her needs.

_____
_____
_____
_____

This form was completed by: _____ Relationship: _____

……

Please return this form and other requested paperwork to our office via drop-off, fax, or email. We will call you as soon an appointment is available. Thank you!

Authorization for Release of Information

Client name: _____ Date of Birth: _____

Persons/Organizations receiving the information:
Please include an/all of the professionals involved in the care of the client for the current diagnosis for which he/she is being seen. This information will be used to assist in providing the most comprehensive care.

Primary Care Physician/Pediatrician: _____
Address: _____
_____
Phone: _____
Fax: _____

Audiologist: _____
Address: _____
_____
Phone: _____
Fax: _____

Physical Therapist: _____
Address: _____
_____
Phone: _____
Fax: _____

Occupational Therapist: _____
Address: _____
_____
Phone: _____
Fax: _____

Speech Therapist: _____
Address: _____
_____
Phone: _____
Fax: _____

Teacher, c/o School: _____
Address: _____
_____
Phone: _____
Fax: _____

My signature authorizes Blue Ridge Speech and Hearing Center the disclosure of use of my medical information with the above indicated professionals.

_____ _____
Signature of client or client's representative Printed name

_____ _____
Relationship to client Date