SPEECH THERAPY CASE HISTORY

Your answers to the following questions will help me understand your concerns. Your answers will be regarded as confidential information. Your answers can be short, but if you need more space, please attach extra sheets of paper. Some of the questions may not seem important to you right now, but all this information will help in understanding you and your child's needs.

IDENTIFYING INFORMATION Today's Date:_____

Child's Name: First:_____ Middle Initial:_____ Last:_____

Date of Birth:_____ Sex: M / F

Address:_____ City/State:_____ Zip:_____

Home Phone:_____

PARENT INFORMATION

Mother's Name:_____ Father's Name:_____

Mother's Cell Phone:_____ Father's Cell Phone:_____

Mother's Work Phone:_____ Father's Work Phone:_____

Person filling out this form:_____ Relationship to child:_____

Who referred you here:_____ Child's Pediatrician:_____

Check the area/s in which you have concerns:	**COMMENTS**
_____ Speech/Language	_____
_____ Feeding	_____
_____ Hearing	Has your child's hearing been screened or evaluated? No_____ Yes_____ Date of test: _____ Who performed test: _____
_____ Vision	_____
_____ Height/Weight	_____
_____ Physical Health	_____
_____ Self-Help Skills	_____
_____ Coordination/Motor Skills	_____
_____ Emotional adjustment	_____
_____ Other	_____

Briefly describe speech/language problems: _____
_____

Age when problem was first noticed: _____

MEDICAL & DEVELOPMENTAL HISTORY

Is this your: _____ natural child _____ stepchild _____ adopted child _____ foster child

If adopted, foster or stepchild, at what age did he/she come into your home? _____

If this is your natural child:
How many pounds did mother gain during pregnancy? _____ Length of pregnancy with this child: _____ mos _____ wks

List any medication or shots (if any) mother took during pregnancy:

_____ _____ _____

_____ _____ _____

Did mother experience any of the following during pregnancy? (check all that apply)
_____ illness _____ Rh incompatibility _____ bleeding/spotting _____ vomiting
_____ injury _____ emotional upsets _____ high blood pressure _____ swelling of hands or feet

Describe labor and delivery (check all that apply) **COMMENTS**
_____ Premature birth _____
_____ Spontaneous onset _____
_____ Induced _____
_____ Normal birth _____
_____ Forceps used _____
_____ Breech presentation _____
_____ Anesthesia used _____
_____ C-section _____
_____ Other _____

Condition of baby immediately following birth (check all that apply)
_____ Normal, no difficulties _____
_____ Jaundiced _____
_____ Breathing difficulties _____
_____ Incubation required _____
_____ Convulsions _____
_____ Difficulties feeding, sucking or swallowing _____
_____ Other _____

Measurements of baby at birth: weight: _____ length: _____

Did baby cry immediately? _____ yes _____ no _____don't know

Where was child born? _____ City/State: _____

Were there any problems during the first month at home? COMMENTS

_____ Excessive crying _____

_____ Feeding/sucking/swallowing problems_____

_____ Other _____

AGE **COMMENTS**

At what age did your child do the following?

Smile _____/_____

Sit alone _____/_____

Walk alone _____/_____

Say 1st clear words _____/_____

Toilet trained (daytime) _____/_____

Dressed self _____/_____

Has your child had any of the following?

Measles _____/_____

Chicken Pox _____/_____

Mumps _____/_____

Tonsillitis _____/_____

Ear Infections _____/_____

Allergies _____/_____

Meningitis _____/_____

Other illness _____/_____

Surgery _____/_____

Other hospitalizations _____/_____

Other _____/_____

FAMILY/SOCIAL HISTORY

_____ BIOLOGICAL PARENTS **_____ FOSTER / ADOPTIVE / STEP PARENTS (circle appropriate)**

MOTHER' NAME: _____ Birthdate:_____

Occupation: _____ Grade completed in school:_____

Current marital status: _____ married _____ single _____ divorced _____separated _____widowed

How long married to current spouse: _____

FATHER'S NAME: _____ Birthdate:_____

Occupation: _____ Grade completed in school:_____

Current marital status: _____ married _____ single _____ divorced _____separated _____widowed

How long married to current spouse: _____

SIBLINGS / OTHERS LIVING IN HOME:

Name	**Birthdate**	**Relationship to child**

Language/s spoken in the home: _____ English only _____ English plus: (list other/s): _____

Any developmental concerns in family members, in both immediate and extended family (include speech/language, hearing, global developmental delays, autism, stuttering, etc.) _____ no _____ yes

Please list family member's relationship to your child and a brief statement of the developmental concern:

_____

SCHOOL INFORMATION

School District: _____ Name of School: _____

Address: _____ Grade: _____

Current teacher:_____ Days/Hours attends: _____

Special Programs ever attended by child:

_____ speech therapy // Name of therapist: _____
_____ physical therapy // Name of therapist: _____
_____ occupational therapy // Name of therapist: _____
_____ special classes // Name of teacher: _____
_____ other // Name of therapist: _____

List schools child has attended (including preschool):

Name/Address of School	Grade	Dates of Attendance

List other persons and places where child has been seen in the past:

Name/Address of Specialist	Testing/Treatment Given	Dates

List the following information regarding your child:

Regular/organized extracurricular activities: _____

Favorite things (food, toy, activities): _____

Strong dislikes: _____

If in school, best/favorite subjects: _____

Least favorite subjects: _____

Which of the following does your child use to communicate?

_____ gestures _____ single words _____ phrases _____ complete sentences _____ follows directions

How well does your child understand you? _____ good _____ fair _____ poor

How well do you understand your child when you know the context? _____ good _____ fair _____ poor

How well do you understand your child when you don't know the context? _____ good _____ fair _____ poor

What do you hope to gain from this appointment?_____

_____

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