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Speech-Language Development, SLP P.C.

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CASE HISTORY FORM

General Information

Patient's Name:_____Date:_____

Date of Birth:_____Age:_____

Address:_____

Telephone (Home)_____(Business)_____

(Cell)_____

Name of person completing the form:_____

Father's name:_____Age:_____ Occupation:_____

Mother's name:_____Age:_____ Occupation:_____

Referred by:_____

Insurance Company_____ID#:_____

Description of problem/major complaint:_____

_____

_____

_____

History of Problem

List names, age, sex, (school, grade) of all other family members (siblings, grandparents) other than patient residing in the home. Please also note any health problems, learning disabilities, or any other problems that these family members might have.

_____

_____

_____

_____

Please note history of previous speech/language therapy: who, when, where; Please explain the course of therapy, response to treatment, and projected goals, if applicable.

_____

_____

_____

At what age did this problem begin? Was it simultaneous with the onset of speech/language development or soon afterward?_____

_____

_____Noticed by who?_____

Has the problem changed (greatened or lessened) over time?_____

Previous treatment of any health problem (other than speech or language):_____

_____

_____

Is your child taking any medication (antibiotics, etc)?_____

_____

What attempt has parent or other family member made to correct this problem at home? How?_____

_____

_____

What is your estimation of the severity of this problem?_____

_____

Is there a family history of speech, language, or hearing problems, learning disability and/or other medical problems? Please Explain._____

_____

How do others react to the problem (adverse comments, negative reactions, etc.) notably, relatives, teachers, or peers?_____

_____

Is your child aware of the problem? How does he/she react?_____

_____

Is there a language, other than English, which is spoken in the home? Is the patient or are (other) family members bilingual?_____

Name/address/phone # of physician or pediatrician:_____

_____

Was your child ever evaluated by the following:

Psychiatrist:_____If yes, by whom, where, when:_____

_____

Pshychologist:_____If yes, by whom, where, when_____

_____

Has your child ever receive counseling?_____

_____

Neurologist:_____

Otolaryngologist (ear, nose, throat)_____

Orthodontist:_____

Physical or Occupational therapist:_____

Do you give permission for these evaluations to be forwarded to SLD?_____

If yes, Please sign *Release of Information* permission forms attached.

Developmental History

Describe the mother's health during pregnancy. Please include illnesses and note which month; length of delivery, instruments used; induced labor; drugs used; difficulty in initiating breathing; evidence of birth trauma; etc. Please explain.

_____

_____

_____

Was pregnancy full-term?_____Birthweight of child:_____

Was your child breast or bottle fed?_____

_____Until what age?_____

Use of pacifier?_____Until what age?_____

Such thumb?_____Until what age?_____

Feeding difficulties?_____

Sleeping?_____Hearing?_____

Ages of the following: Held head up:_____Sat unassisted:_____

Walked:_____Bowel/bladder trained:_____

Did your child walk much or little?_____Please describe early crying, babbling, any unusual sounds?_____

Were sounds used in a playful way?_____

_____

Ages of cooing:_____babbling:_____1st word:_____

Example of first word_____age of 2-words_____

Examples of two words_____

Making full sentences (age):_____examples of sentences:_____

_____

Does your child have difficulty jumping, walking, throwing a ball, holding a pencil (manual dexterity or coordination)?_____

_____

Which hand does your child prefer?_____

Medical History

Has there been a diagnosis of a medical problem?_____

Note any illnesses, injuries, or surgery:_____

Seizures?_____

Tonsils, adenoids, allergies?_____

Is your child a mouth breather?_____

Ear infections?_____Since what age?_____

Until what age?_____

Was vision ever tested?_____Wear glasses?_____

Has your child had a hearing test? Was your child seen by a doctor for a hearing problem? Who, when, where? Please describe the results:_____

_____

Date last hearing was performed:_____Was it performed by a certified audiologist?_____

School History

Name/address of school: _____

Age when entered school (Preschool):_____Kindergarden:_____1st Grade_____

Present grade placement: _____Failed/skipped grade?_____

Difficulty with any subjects?_____

Any special talents?_____

Is your child's reading, spelling, and writing on grade level?_____

Any other learning problem?_____

Does your child receive any special services in school (e.g., resource room, counseling, speech-language therapy, reading)?_____

Are there reports/recent evaluations available?_____

How does your child get along with classmates?_____

Peers (if not in school)?_____Teachers?_____

Social History

How does your child get along with brothers and sisters?_____

_____

Parents and other adults?_____

What do you do to make your child behave (use of punishment)?_____

_____

How does your child respond to discipline?_____

Is there anything your child does which you find difficult to cope with?_____

_____

Who spends most of the time with your child?_____

How would you describe your child's personality?_____

_____

Please describe any other behaviors (e.g., nail biting, thumb-sucking, over-activity, temper tantrums, destructiveness, management problems, etc.) Please explain.

_____

_____

_____

Is there anything you would like to add which may prove helpful?_____

_____

_____

_____

_____

_____ _____

Signature Relationship to child/Patient/Date

I give permission for information from this Case History Form to be used in an evaluation report generated by Speech-Language Development SLP P.C.

_____

Signature/Date