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CASE HISTORY FORM

Identifying Information

Child's Full Name_____ Date:_____
Person Completing Form: _____ Referred by:_____
Date of Birth:_____ Age: _____ Sex:_____ Lives with:_____
Home Address:_____Telephone:(_____)_____

Family History

Mother:_____ Age:____ Occupation:_____ Bus. Tel.:_____
Speech, language, or learning related problems:_____
_____
Father:_____ Age:____ Occupation:_____ Bus. Tel.:_____
Speech, language, or learning related problems:_____
_____

Siblings Names:	Ages:	Speech, language, or learning related problems:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other people living in the home:_____
Language spoken in the home (other than English)_____

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Birth History

Pregnancy : Normal ____ Problems___ (If problems please describe)_____

_____

Medications taken during pregnancy:_____

Other pregnancies: How many?____ If problems please describe:_____

_____

Obstetrical: Hospital:_____ Doctor:_____

Birth Weight:_____ Labor: Normal:____ Induced:___ Length of labor:_____

Any drugs or anesthetics?_____ Which?_____

Special considerations: Caesarian_____ Premature:_____ Breach:_____ Child rotated:_____

Chord around neck:____ Twin(1st born, 2nd born)_____ Baby blue:_____ Baby yellow:_____

Baby bruised:____ R.H. negative:____ Transfused:____

Special care: Oxygen:___ For how long?_____ Incubation:___ For how long?_____

Hospital stay: Child:_____ days Mother:_____ days

Medical History

Pediatrician: _____ Telephone (301)_____

Address:_____

Date of the last physical exam:_____Date of last hearing screening:_____ Results:_____

Tubes in ears:_____ Date inserted:_____ Date removed:_____

Date of last vision screening:_____ Does your child wear glasses?_____

Allergies?_____ Please describe:_____

Current medications (include name, dosage and reason)_____

_____

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Medical Background

(Check which applies to your child, state age, and complications)

Frequent Colds_____ Infectious mono_____
Frequent respiratory infections_____ Endocrine disturbance_____
Frequent earaches or infections_____ Spinal meningitis_____
Hearing loss_____ Heart trouble_____
Chicken Pox_____ Epilepsy_____
Excessive high fever_____ Cerebral palsy_____
Convulsions_____ Serious injuries_____
Operations_____ Allergies_____
Other illnesses_____
Hospitalizations? When_____Where_____ Why_____
_____

Motor Development

When did your child begin to:
Sit up_____ Crawl_____
Walk (at least 5 steps)_____ Jump (with 2 feet)_____
Go up stairs one foot after the other_____
Gain bladder control_____ Gain bowel control_____
Establish hand preference for eating_____ Which hand_____
Establish hand preference for writing_____ Which hand_____
Establish hand preference for throwing_____ Which hand_____
Check any if appropriateL Trips easily_____ No fear_____ Runs into things_____
Trouble with stairs____ Afraid of climbing____ Clumsy with hands____ Climbs poorly_____
Please describe any other motor concerns:_____

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Feeding Development

When did your child begin to:
Drink independently from a bottle_____ Drink from a cup by self_____
Eat table foods_____ Use a spoon_____
Do you have any concerns about: (if so explain)
Biting_____ Chewing_____
Drinking_____ Swallowing_____
Does your child have any food allergies/preferences? (please explain)_____
_____

Speech and Language Development

When did your child begin to:
Coo (primarily vowel sounds)_____ Babble (da-da-da)_____
Jargon (da-bee-boo) sounds like talking without true words_____
Say his/her first word_____ What was it?_____
Describe the circumstances in which it occurred_____
Combine words (e.g."Mommy go", "want juice")_____
Was there ever a time when your child's speech and language skills regressed or he/she stopped talking?
_____ When_____
Please describe the circumstances_____
How intelligible (understandable) is your child's speech to the family_____ To outsiders?_____
What concerns do you have about your child's speech and language skills at this point in time?_
_____
_____
How do these concerns interfere with: the school setting?_____
_____
The home environment?_____
_____
Interpersonal relationships (social skills)? E.g. playing with other children_____

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_____

Have speech and language skills been evaluated before?_____

When?_____ Where?_____

Did evaluation lead to any treatment?_____ Where?_____

By whom?_____

Psychological and Neurological Development

Has child had a psychological exam?_____ When?_____

For what reason?_____

Name, address, and tel. Of psychologist_____

Has child had a neurological exam?_____ When?_____

For what reason?_____

Name, address, and tel. Of neurologist_____

Check any that apply to your child:

___ nervousness ___ hyperactive ___sleeplessness ___ staring at lights/objects

___ bedwetting ___ nightmares ___sad ___aggressive

___ restlessness ___ destructive ___ withdrawn ___ tics

___ excessive shyness ___ temper tantrums ___ short attention span___ Rock or roll

___ easily distracted ___ head banging ___ hurts self ___ being sensitive to touch

___ fearful of new citations, sitters, or strangers ___ staring at lights or objects

___ persistent habits e.g. nail biting, thumb sucking ___ annoyed by loud sounds

___ perseverative behavior (doing things over and over)

How are these concerns manifested at home?_____

At school?_____

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Educational Development

Schools attended (including preschool): Grades: Dates:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Grades repeated:_____

Current school placement:_____

Name_____

Address_____

Phone_____ Teacher_____ Grade_____

Child's attitude towards school:_____

Specific concerns about current school programs_____

_____

_____

Special services (e.g. tutoring) received at school_____

Who provides services_____ What subjects_____

How often?_____

Special services received privately_____

Who provides services_____ What subjects_____

How often?_____

Address_____ Tel._____

What information are you hoping to obtain as a result of this evaluation?_____

_____

_____

_____

Thank you very much.

Diane Lewis, MA, CCC/SLP