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Certified Speech/Language Pathologist
Listening and Spoken Language Specialist

CASE HISTORY

Name_______________________________________DOB______________Age____________

Sex_________________ Race (optional)________________

Referred by____

Address____
Street City State Zip

Preferred Phone_________________________ Alternate Phone___________________________

Email____

Family Physician________________________ Address___________________________________

Father's Name____ Age________________

Address____ Home Phone__________

Occupation_________________________ Employer_______________________________________

Marital status______________________ Education______________________________________

Mother's Name____ Age________________

Address____ Home Phone__________

Occupation_________________________ Employer_______________________________________

Marital status______________________ Education______________________________________

List names and ages of child's sisters and brothers__________________________________

____

Relationships and ages of others living in the home__________________________________

____

Insurance Information

Medical Insurance Company____

Address____
Street City State Zip

Group or Policy #________________Name of Policy Holder ____________________________

Policy Holder's ID #: ______________________Date of Birth: ______________________________

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Statement of the Problem

Describe the problem: ____

____

When the problem was first noticed: ____

Describe how you and others in the family react to this problem____________________

____

What do you think causes this problem? ____

____

Describe what has been done about it- when and where: ____________________________

____

General Development

PREGNANCY

Mother's state of health: ____
Length of pregnancy: ______________________ Medications Taken: __________________________
Difficulties during pregnancies: ____
Miscarriages or stillborns: ___________Number of living children: __________________________

DELIVERY

Hours of labor: ____________________ Was labor induced_________________________________
Complications: ____
Type of Delivery: Normal______ Instrument__________ Breech_________ Caesarean________
Drugs or Anesthesia used: ____
Single or Multiple Birth: ____________________________

CONDITION AT BIRTH

Full term: _____ Premature: ______ Jaundiced: ______ Bleeding: ______ RH Factor_______ Breathing
Difficulties: _______________
Birth Weight: ____________ Length: ___________ Age at discharge from nursery_____________
Evidence of birth injury: ____
Congenital Birth Defects: ____
Health during first weeks of life: ____
Comments: ____

DEVELOPMENTAL

AT what age did the child:
Sit alone: _________Crawl: _______________Stand alone: ____________Walk: _________________
Feed Self: ___________ Drink from a cup: ___________________ Bowel control: ________________
Bladder control: _____________________________ Dress self: ______________________________

Was the child bottle or breast fed: ________________ Age when weaned: ___________________
Any feeding problems: ____
Does your child choke while eating? ______________ On what foods? _______________________
Does your child suck his/her thumb? ________Does your child trip or stumble often? __________
Does the child drool? _______

MEDICAL HISTORY

Describe any unusual diseases or surgery: ____

____

Describe any serious illnesses, accidents, or high fevers: ___________________________________

____

Earaches or ear infections: ____

Does your child have frequent coughs, colds, sinus congestion, and/or respiratory infections? _____

____

List any medication your child is currently taking and why:

____

____

Who is your child's pediatrician? ____

List of any known allergies and to what: ____

____

Have ears been tested: _____________When: __________________ By whom: _______________

Results: ____

Do you think your child hears adequately? ____

Does your child's hearing appear constant or variable? ___________________________________

Does your child's hearing worsen when he/she has a cold? ________________________________

PREVIOUS EVALUATIONS AND/OR TREATMENT

Has your child ever been evaluated and/or treated for hearing, vision, speech-language motor, seizure, behavior, emotional, or learning problems: ____________________________________

Dates: ___________________________________ By whom: ______________________________

Type of evaluation and/or treatment: ____

____

Results and/or recommendations:

____

____

SPEECH-LANGUAGE HISTORY

Did your child make babbling and cooing sounds during first six months? ____________________

Age at which your child spoke single words: ____

Two-word phrases: ______________Spoke so the family could understand him/her ___________

____

Age at which a speech-language problem was first suspected: ____________________________

Does your child follow simple directions such as "Get me the ball?" ________________________

Is your child aware of the problem? ____

Does your child's speech pattern cause him/her to be shy, withdrawn or maladjusted? __________

____

Are there any known defects of the child's tongue, palate, nose, throat, ears, lips, or teeth? _____

____

Are there any family members with speech, language, or hearing problems? __________________

What is the primary language spoken in the home? ____________________________________

Are there any other languages spoken in the home? _____________________ Does your child enjoy speaking? _________Does your child enjoy playing with other children? _______________

Current grade, school and district child is enrolled in: _________________________________

____

This form was completed by: ____

Relationship to patient: ____