PLEASE NOTE A SCRIPT MUST BE PROVIDED FROM YOUR PCP BEFORE THE EVALUATION:
I understand and will obtain one or my evaluation will be cancelled, and I will owe a $50.00 cancellation fee: **Initial to confirm you understand this**: ___________

Case History Form-Pediatric

Date: _________________
Person filling out this form: ___________________________________
Child's Name: ____ Date of Birth: ______________________
Address_______________________________ City: _____________ Zip: __________________
Home phone: ______________________ Daytime phone: ________________________Cell: ____________________
Mother's Name: ____________________________ Father's Name: __________________________________

Child lives with (check one):
Birth Parents _______ Foster Parents ______ One Parent _______ Adoptive Parents______ Parent and Stepparent _______ Other ________
Emergency Contact and number: ____________________________
Other Siblings: (names, ages): ____
Referring physician: ___________________________________ Address: _______________________
City: ______________________ Zip: ________________ Phone: _________________________
Date of injury, accident, incident or first noticed symptoms (must have a month day and year): MONTH: ____________ DAY: __________ YEAR: ___________
When was the problem first noticed: MONTH: ___________ YEAR: _____________

Any surgeries related to the issue? If so what surgery and when was the surgery performed:
____

Have you seen any other speech-language specialist(s)? Who and when? What were their conclusions or suggestions?
____
____

How do you feel your child's problem is affecting them emotionally, educationally, etc.?
____
____

Have you seen any other specialist (physical/occupational therapists, surgeons, physicians, psychologists, neurologists, etc.) concerning your problem? If yes, indicate the type of specialist,

when you were seen and the specialist's conclusions or suggestions.

____

____

Medical History:

Please check the following if they apply:
Cancer: _______(where:) __________________ Intubation / ventilation:_______ Tracheostomy: _______
Cardiac concerns: _________Hearing Loss _______ PE Tubes: _________ Allergies ______ GERD/Reflux ______ Noise Exposure ______ Infections ______ Encephalitis ______ Seizures ______ High Fever ______ Head Injury ______ Meningitis ______ Stroke ______ Sinusitis ______ Measles/Mumps______ Concussion ______ Tinnitus ______ Mastoiditis ______ Headaches ______ Pneumonia ______ Chronic Cough ______ Anxiety ______ Asthma ______ Difficulty Breathing _____ Tonsillitis _________ Frequent colds ________ Vision problems ________ Wears glasses _________ Tonsillectomy ________ Nasal congestion ________ Difficulty sleeping ________ Cleft Palate ________ Chronic ear infections __________ Snoring _________ Breathing difficulties_________ Adenoidectomy ________ Seasonal allergies ________ Emotional/Psychological:_______ Neurological disorders: ________ Other medical/genetic hx ____________________________________

Check all that apply:

Unusually active/fidgety _____ Low muscle tone ________ Clumsy __________
Easily overwhelmed ________ Overly sensitive to sound __________ Overly sensitive to touch __________
If you checked any of the above, please explain: ____

Is there a family history related to your concern for why you are seeking our services for your child?: Y / N Please explain:

____

____

Why is an evaluation being requested? ____

____

Was the child born premature? If yes, at how many weeks? ______________________
Was the child healthy at birth? Yes No
If no, please explain:

Was there anything unusual about the pregnancy or delivery? Yes No

If yes, please explain:
____

Date of last hearing screening: _______________ Location: Results: Pass / Fail
Date of last vision screening: ________________ Location: Results: Pass / Fail

Check all that apply:
Thumb/finger sucking ______ Messy eater _______ Food allergies ________
Pacifier use _______ Limited diet _______ Weight issues ________
Difficulty nursing ________ Food texture sensitivity _______ Picky eater ________
Reflux/Colic ______ Drooling observed ________ Choking/coughing while eating ________
Tongue thrust ______ Tongue or lip tie present _______ Sensitive gag reflex _________

If you checked any of the above, please explain: ________________________________
____
____

Was your child bottle fed? _______ How long: _____
Breastfed? ________ How long? ________

Does your child primarily breath through their... nose ______ mouth ______ unsure _______

Indicate the approximate age at which your child reached the following milestones:
Sat alone _______ Walked ________ Grasped crayon/pencil ______ Crawled ________
Toilet trained ________ Began to scribble/draw _______
Do you consider any physical/motor milestones to be delayed or impaired? Yes / No
If yes, please explain: ____

Has your child been diagnosed with a developmental disability or behavioral disorder? Yes No
If yes, please specify: ____

Educational/Academic History

Does your child attend school?
Child's school/district: _______________________________________
Grade: ________________
Does your child have an active IFSP or IEP? YES NO
Is your child reading? YES NO
Did they have or are they having a difficult time learning to read? YES NO

Speech & Language Development

Indicate the approximate age at which your child reached the following milestones:
Babbled ________
Put two words together _________
Said first words: ___________
Spoke in short sentences: __________
Was your child a quiet infant (limited /vocalizations/ babbling)?
Did your child produce any consonant sounds in babbling by 12 months?
(e.g., "mmm", "dah", etc.) YES NO

Did your child produce consonant + vowel syllables by 18 months?
(e.g., "doo", "buh", "no", etc.) YES NO
Did/does your child produce /k/ or /g/ sounds in their babbling? YES NO
(e.g., "goo", "gah", "kah", etc.) YES NO
Did your child have 5 or more consonant sounds at 2 years old? YES NO
Did/does your child prefer to use /m/, /p/, or /b/ sounds over others? . YES NO
Did anything concern you about your child's speech development?
If yes or unsure, please explain: ____

Does your child prefer to communicate with: Gestures _____ Words ______ Both ______ Neither _____
Does your child:
Follow simple directions? YES NO
Follow complex or multi-step directions? YES NO
Ask questions? YES NO
Understand what you are saying? YES NO
Identify objects and actions easily? YES NO
Respond correctly to yes/no questions? YES NO
Is your child's speech easily understood by most people? YES NO
If you checked "NO" for any of the above, please explain: ____________________________________
Is your child aware of or frustrated by any speech difficulties? YES NO
If yes, please explain: ____

Please provide some examples of a typical sentence or utterance your child says:
____

Signature: ______________________________________Date: _________