Pediatric Speech and Language Case History Form

Identifying and Family Information:

Child's Name: _____ **Child's Date of Birth:** _____ **Sex:** : ❑ M ❑ F

Child's Social Security Number: _____

Child's Race/Ethnicity: ❑ Caucasian, Non-Hispanic ❑ Hispanic ❑ African-American
❑ Native American ❑ Asian or Pacific Islander ❑ Other: _____

Child's Primary Language: _____

Other Languages Spoken in the Home (and by whom): _____

Does the Child Speak the Language(s)? ❑ Yes ❑ No

Does the Child Understand the Language(s)? ❑ Yes ❑ No

Referred By: _____

Reason for Referral: _____

Child's Primary Care Physician (PCP): _____

PCP's Phone Number: _____ **PCP's Fax Number:** _____

Mother's Name: _____ **Mother's Cell Phone:** _____

Mother's Work Phone: _____ **Mother's Email:** _____

Mother's Address: _____

Mother's Date of Birth: _____ **Mother's Occupation:** _____

Father's Name: _____ **Father's Cell Phone:** _____

Father's Email: _____ **Father's Work Phone:** _____

Father's Address: _____

Father's Date of Birth: _____ **Father's Occupation:** _____

Child Lives With (check one of the following): ❑ Birth Parents ❑ Foster Parents ❑ One Parent – Mother
❑ One Parent – Father ❑ Adoptive Parents ❑ Parent (Mother) and Step-Parent
❑ Parent (Father) and Step-Parent ❑ Other: _____

When was your child's most recent hearing evaluation/screening? _____

What were the results? _____

When was your child's most recent vision evaluation/screening? _____

What were the results? _____

Describe your concerns regarding your child's speech and language skills: _____

_____

When did you first become concerned? _____

Does your child present with any current medical and/or communication diagnoses? ❑ Yes ❑ No

If yes, please describe (with dates of onset, if possible): _____

_____

Other Children in the Family:

Name Age Sex

_____

_____

_____

Has your child previously received a speech and language evaluation/screening? ❑ Yes ❑ No

If yes, where and when? What were the results? _____

_____

Has your child previously received speech therapy services?

If yes, where and when? _____

Who was your child's Speech-Language Pathologist? _____

What were the treatment goals? _____

Has your child previously received any other therapy services (i.e., physical therapy, occupational therapy, counseling, vision, behavioral, etc.)? ❑ Yes ❑ No

If yes, please describe: _____

Is there a family history of speech/language/neurological/hearing deficits? ❑ Yes ❑ No

If yes, please describe: _____

Have any of the child's immediate family members been diagnosed with any of the following? Please indicate "F" for child's father, "M" for child's mother, "S" for child's sibling, "MGF" for child's maternal grandfather, "MGM" for child's maternal grandmother, "PGF" for child's paternal grandfather, and "PGM" for child's paternal grandmother.

_____Learning Disability _____Dyslexia

_____Speech and Language Delay/Disorder _____Fluency Disorder (i.e. Stuttering)

_____Sensory Processing Disorder _____Auditory Processing Disorder

_____ADD/ADHD _____Autism/PDD/other

Describe your personal goals for your child's speech therapy process: _____

_____

Describe any other concerns regarding your child's development: _____

_____

Does your child present with an awareness or frustration toward his or her speech and language deficits?

_____

Speech, Language, and Hearing Development:

When did your child begin to "coo" or "babble?" _____

When did your child produce his or her first word? _____

What was your child's first word? _____

When did your child begin to use 2-3 word phrases? _____

Did your child ever appear to "stop talking" or present with a regression in speech/language skills?

❑ Yes ❑ No If yes, please describe: _____

Approximately how many words does your child verbalize without assistance?

❑ 1-5 ❑ 6 -10❑ 10-15 ❑ 15-25 ❑ 25-50 ❑ Over 50

How does your child communicate his or her needs and intentions?

❑ Via gestures (e.g. pointing). ❑ Single words ❑ Phrases ❑ Sentences

Does your child produce any sounds incorrectly (e.g. articulation concerns)? ❑ Yes ❑ No

If yes, please describe: _____

Does your child hesitate, "get stuck," repeat, or stutter on sounds or words? ❑ Yes ❑ No

If yes, please describe: _____

When did you first notice this behavior? _____

Can your child tell a simple story? ❑ Yes ❑ No

How well can your child be understood by familiar individuals (indicate "A" for all the time; "M" for most of the time; "S" for some of the time; or "R" for rarely)? _____

How well can your child be understood by unfamiliar individuals (indicate "A" for all the time; "M" for most of the time; "S" for some of the time; or "R" for rarely)? _____

Does your child present with appropriate eye contact when speaking with individuals? ❑ Yes ❑ No

Does your child consistently respond to his or her name? ❑ Yes ❑ No

Does your child appear to understand what is communicated to him or her? ❑ Yes ❑ No

Is your child able to follow simple directions? ❑ Yes ❑ No

Please provide specific examples: _____

Birth History:

Did the child's mother present with any medical complications during the pregnancy? ❑ Yes ❑ No

If yes, please describe (as well as any medical attention received): _____

_____

Did the child's mother consume any prescription and/or nonprescription medication during pregnancy?

❑ Yes ❑ No If yes, please describe: _____

Was the child considered full-term? ❑ Yes ❑ No If no, what was the gestational age? _____

What type of delivery was present? ❑ Vaginal ❑ Cesarean section

How long did the child remain in the hospital prior to being discharged? _____

Feeding/Swallowing/Oral Motor History

Was the child breast-fed or bottle-fed? ❑ Breast-fed ❑ Bottle-fed

If breast-fed, for how long? _____

Do you have any past/present concerns regarding the child's feeding, swallowing, and/or oral motor skills?

_____

What age did your child begin: Puree foods (e.g., rice cereal, Stage I jarred food)? _____

Soft chewables? _____ **Table food?** _____

Is your child a "picky eater?" ❑ Yes ❑ No

List any foods that the child once ate and has since stopped eating: _____

Please list the child's preferred foods: _____

Did the child previously present with difficulty transitioning to different food textures? ❑ Yes ❑ No

If yes, please describe: _____

Child currently consumes food/drinks via (check all that apply): ❑ Finger feeds ❑ Uses fork ❑ Uses spoon ❑ Drinks from open cup ❑ Uses straw

Does the child currently suck his or her thumb/fingers and/or place objects in the oral cavity? ❑ Yes ❑ No

If yes, please describe: _____

Please describe when the following first occurred: _____Sat Up _____Crawled _____Stood _____Walked _____Ran _____Bladder Trained _____Bowel Trained

Which hand does the child use more frequently? ❑ Right ❑ Left ❑ No preference

Does your child present with any allergen complications? ❑ Yes ❑ No

If yes, please describe: _____

Does your child currently take any medication? ❑ Yes ❑ No

If yes, please describe (with name of medication and dosage): _____

_____

Does your child present with a history of the following? (please select all that apply): ❑ adenoidectomy ❑ encephalitis ❑ adenoidectomy ❑ seizures ❑ flu ❑ sinusitis ❑ breathing difficulties ❑ head injury ❑ sleeping difficulties ❑ chicken pox ❑ high fevers ❑ colds ❑ measles ❑ tonsillectomy ❑ ear infections ❑ meningitis ❑ tonsillitis ❑ mumps ❑ vision problems ❑ ear tubes ❑ scarlet fever

Describe any other illnesses, accidents, surgical procedures, injuries, and hospitalizations of the child?

_____

Child prefers to primarily play: ❑ Alone ❑ With older children ❑ With younger children ❑ With adults

Is your child sensitive to loud sounds? ❑ Yes ❑ No Bright lights? ❑ Yes ❑ No

Does the child do the following?

_____Localizes (locates) the source of sound

_____Responds consistently to sound

_____Ignores environmental sounds.

_____Requires verbal repetition of information

_____Listens selectively in the presence of noise.

Please describe your child's behavioral characteristics (check all that apply): ❑ cooperative ❑ motivated to complete tasks ❑ restless ❑ attentive ❑ poor eye contact ❑ willing to try new activities ❑ easily distracted/short attention ❑ plays alone for reasonable length of time ❑ destructive/aggressive ❑ separation difficulties ❑ withdrawn ❑ easily frustrated/impulsive ❑ inappropriate behavior ❑ stubborn ❑ self-abusive behavior

Educational Information

What school/daycare does the child currently attend? _____ Grade?_____
Address of school: _____

Has your child ever been retained in school? ❑ Yes ❑ No If yes, please describe: _____

Has the child ever received therapy services through his or her enrolled school district? ❑ Yes ❑ No
If yes, please describe: _____
What are your child's strengths and/or best subjects in school? _____
_____
What are your child's weaknesses and/or most difficult subjects in school? _____
_____

Has your child been seen by any other medical professionals, other than his or her PCP? ❑ Yes ❑ No
If yes, please describe: _____

Emergency Contact Information:

Name:_____ Relationship to child: _____

Telephone Number:_____ Cell Number:_____

Name of individual who completed this form: _____

Relationship to child: _____

Date: _____