Speech Pathology Solutions, LLC

Child Case History Form

General Information

Child's name: ____ Date of Birth: ____________________________

Address: ____ Phone number/carrier:_____________________

City: ____ Zip: ____________________________________

Does the child live with both parents? ____

Mother's Name: ____ Age: __________________________________

Mother's Occupation: ____ Business Phone: _________________________

Father's Name: ____ Age: __________________________________

Father's Occupation: ____ Business Phone: _________________________

Referred By: ____ Phone: ________________________________

Address: ____

Pediatrician/Family Dr.: _____________________________________ Phone: _______________________

Address: ____

Brothers and Sisters (include names and ages)

____

____

What Languages are spoken in the home? What is the primary language?

____

With whom does the child spend the most of his or her time with?

____

____

How does the child interact with others (e.g., shy, aggressive, uncooperative, etc.)?

____

____

What motivates your child? (specific toys, games, music, etc.)

____

____

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

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____

Person completing form: ____

Relationship to child: ____

Signed: ____ Date: _____________________

Education History

School: ____ Grade: ____________________________

Teacher(s): ____

How is the child doing academically (or pre-academically)?

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____

Does the child receive special services (OT, PT, ST, RTI) within the school setting? If yes, describe.

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If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals.

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Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.)

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Length of pregnancy: _______________________________ Length of labor: ______________________

General condition: _________________________________ Birth weight: _________________________

Circle type of delivery: head first feet first breech Caesarian

Were there any unusual conditions that may have affected pregnancy or birth?

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Medical History

Provide the approximate ages at which the child suffered the following illnesses or was diagnosed with the following:

Allergies to medications or environment ______________________________

Pneumonia	________	Dizziness	________	Recurring Strep Throat	________
Seizures	________	Sinusitis	________	Tongue/Lip Tie	________
Asthma	________	Tinnitus	________	Submucous/Cleft Palate	________
Colds	________	Tonsilitis	________	Chromosomal Disorder	________
Croup	________	Meningitis	________	Auditory/Sensory Processing Disorder	________
Influenza	________	Ear Infections	________	Autism Spectrum Disorder	________
Headaches	________	ADD/ADHD	________	Other	________

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement, etc.)?

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____

Describe any major accidents or hospitalizations.

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Is the child taking any medications? If yes, identify.

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Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl ____________________ Sit ______________________ Stand ________________________

Walk _____________________ Feed Self _________________ Dress Self ____________________

Use toilet _________________________

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination? ____

____

____

Does your child receive outpatient Occupational or Physical therapy services? What skills are these services targeting?

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____

____

Speech/Language/Hearing Development and History

Has the child's hearing been tested? NO   YES

Date of most recent test _____________ Results: PASS   FAIL RIGHT   FAIL LEFT   FAIL BOTH

If your child's hearing has not recently been tested, describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.).

____

____

At what age did your child do the following:

Use single words (e.g., no, mom, doggie, etc.): __________________

Combine words (e.g., me go, daddy shoe, etc,): _________________

Name simple objects (e.g., dog, car, tree, etc,): _________________

Use simple questions (e.g., Where's doggie? Etc): _______________

Engage in conversation: ___________________________________

Currently communicates by using: Gestures   Sounds   Words   Phrases   Sentences

Describe the child's speech-language problem.

____

____

____

Has any other speech – language specialists seen the child? Who and When? What were their conclusions or suggestions?

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____

____

Feeding/Swallowing History

Describe behaviors during meals. Is mealtime stressful? Why?

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____

____

Has your child been tested for food allergies? What kind? Results?

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Circle if your child experiences or has a history of:

Gagging	Choking	Mouthing toys/fingers
Vomiting	Sucking	Spitting out non-preferred foods
Reflux	Drooling	Difficulty swallowing
Chewing	Overstuffing	Diarrhea

Has your child used a pacifier? At what age did they stop/are they continuing to use it?

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In infancy did your child breast or bottle feed? Did they have any difficulties with these tasks?

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Does your child accept a variety of foods and food groups (i.e. meats, vegetables, fruits, pasta, sandwiches, desserts)?

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Circle the following textures and temperatures your child eats:

Puree	Soft foods	Hard/Crunchy foods	Mixed consistencies
Cold	Room temperature	Hot	

If not circled, does your child actively avoid or express disgust when asked or offered these textures? YES NO

Does your child self-feed? YES NO

Circle the following utensils your child uses:

Hands Spoon Fork

Adaptive utensils: ______________________________________

Circle the following that your child drinks from:

Hard Spout Sippy Cup Straw cup 360 Cup Open Cup

Bottle Other: ____

DIET SUMMARY

Food Allergies:

BREAKFAST	
LUNCH	
DINNER	
SNACKS	
DRINKS	
NON-PREFERRED FOODS	