

SPEECH PATHWAYS, P.C.

CHILD CASE HISTORY

Name: _____ Date of Birth: _____ M F
Mother's Name: _____ Father's Name: _____
Referred by: _____ Reason for referral: _____

Family History

Brothers/Sisters	Date of Birth	Sex	Speech/Hearing/Medical Problems
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____

Has any member of the patient's family had?:

Yes No

___ ___ speech or language problems?
___ ___ hearing problems?
___ ___ learning disability?
___ ___ cleft lip or palate?
___ ___ mental retardation?

Relationship to Patient

Which languages are spoken in the home? _____
Which language is most commonly used by the patient? _____

Maternal, Birth and Early Developmental History

Mother's health during pregnancy? Good Fair Poor Complications during pregnancy? No

Yes, explain _____

How long was pregnancy? Full term Premature by _____ weeks Labor and delivery: normal Check if any of the following conditions were present at birth: ___ cord wrapped around neck; ___ jaundice; ___ Rh incompatibility; ___ convulsions; ___ blood transfusions; ___ respiratory distress; ___ heart problems; ___ hemorrhage; ___ blue color; other: _____

Check if any of the following were present at the child's birth: ___ oxygen given (how long? _____); ___ congenital malformations; ___ birth injuries; ___ incubator required (how long? _____); ___ sucking or feeding problems; ___ motor weakness; other: _____

Medical History

Has the patient's health been: ___ Good ___ Fair ___ Poor Explain: _____

Has the patient ever had:

Yes No

___ ___ Scarlet fever
___ ___ Diphtheria
___ ___ Sinus
___ ___ Earaches
___ ___ Chronic colds
___ ___ Asthma

Yes No

___ ___
___ ___
___ ___
___ ___
___ ___
___ ___

Yes No

___ ___
___ ___
___ ___
___ ___
___ ___
___ ___

Frequent Headaches
Diabetes
Epilepsy
Poor Coordination
Cerebral palsy
Head injury

Allergies: _____

Hospitalizations: _____

Surgeries: _____

Serious illnesses: _____

What medications and dosage is the patient taking? _____

Has the patient's vision been tested? ___ Yes ___ No When? _____ By Whom? _____

What were the results? _____

Has the patient's hearing been tested? ___ Yes ___ No When? _____ By Whom? _____

What were the results? _____

Developmental and Educational History

At what age did the patient do the following:

_____ Support head _____ Sit up _____ Crawl _____ Stand _____ Walk _____ Feed self with hand
_____ Feed self with spoon _____ Bladder control _____ Bowel Control _____ Babbling
_____ Begin to say words _____ Put 2-3 words together _____ Talk in sentences

Does the patient have or do any of the following? _____ nail trimming; _____ bed wetting; _____ food fadisms; _____ sleeping problems;
_____ temper tantrums; _____ day dreaming; _____ abnormal aggressiveness; _____ poor concentration; _____ mood swings;
_____ hyperactivity

What school does the patient attend? _____ Grade: _____ Teacher: _____
Address: _____ Phone: _____

How is the patient's general school performance? _____ good _____ fair _____ poor

What is his/her best subject? _____ Most difficult subject? _____

Reading level: _____ grade Writing level: (check all that apply) _____ writes letters or numbers _____ writes name _____ writes
address, phone _____ writes functional phrases (grocery list, short notes) _____ makes marks on a page _____ writes paragraphs _____ writes
stories

Has he/she ever been in a special education class? _____ Why? _____

Has he/she ever had help from a resource teacher? _____ For what? _____

Has he/she ever been tested at school? _____ Why? _____

Results: _____

Communication Concerns

What concerns you or the patient most about the patient's communication (oral or written)? _____

Who first noticed the problem? _____ When? _____

Did the patient's speech or language development seem to stop? _____ When? _____

Is the patient ever frustrated or embarrassed by his/her speech? _____ Has there been a change in the patient's speech in the
past 6 months? _____ If so, describe: _____

What effects have been made to help the patient's communication? _____

How is the patient at following directions? _____ carrying on a conversation? _____
being understood by the family? _____ being understood by peers? _____
being understood by teachers or boss? _____

Has the patient ever had speech therapy? _____ When? _____

Where? _____ Results? _____

What problems other than speech does the patient have that concerns you? _____

What specific questions about the patient's communication do you want answered? _____

Fine Motor and Self Help Skills

What is the patient's hand preference? Left Right

Which self help skills has the patient mastered? (check all that apply)

_____ feeding _____ bathing _____ teeth brushing _____ hair care _____ dressing _____ toileting _____ fastening buttons _____ working zippers
_____ setting tables _____ pouring liquids _____ performing household tasks: _____

Has the patient ever been tested or treated by an Occupational Therapist? _____ When? _____

Results: _____