CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

CASE HISTORY FORM

Speech-Language, Tongue Thrust, Feeding Evals

Date_____

Person filling out this questionnaire_____

Relationship to child _____

Child's Doctor:_____

Doctor's Address_____

_____

Do you want a copy of our report sent to the pediatrician? Yes___No___

To what other professional persons or agencies do you want a report sent (please provide name/address)?

PLEASE ATTACH A RECENT PHOTO OF YOUR CHILD HERE

_____

_____

Who can we thank for telling you about our practice? _____

IDENTIFYING INFORMATION

Name of child_____Nickname_____

Date of Birth _____ Child's age _____

Address_____

City_____State_____Zip_____

If the address of either parent is different from that of the child, please indicate:_____

_____

Home#_____Cell#_____Work#_____

Alternate phone #_____Email address _____

I prefer to be contacted by: email_____ cell phone_____ work phone_____ home phone_____

STATEMENT OF THE PROBLEM

Describe what problem(s) your child is having with speech, language, feeding, and/or hearing:

_____

_____

_____

_____

List any other concerns you have regarding your child's development:

Does your child have a formal diagnosis? Yes____ No_____ If yes, what is it?_____

When was it made?_____By whom?_____

FAMILY HISTORY

	Name	Age	Occupation	Education
Parent 1:				
Parent 2:				

Other children in the family:

Name	Sex	Age	School-Grade

Have any members of your immediate family been diagnosed with any of the following:

(indicate "F" for father, "M" for mother, or "S" for sibling)

_____ learning disability

_____ dyslexia

_____ speech and language delay/disorder

_____ sensory processing disorder

_____ auditory processing disorder

_____ ADD/ADHD

_____ autistic spectrum disorder/PDD

_____ other, please explain _____

BIRTH HISTORY

Check which is applicable: This is our biological_____foster_____adopted_____child

Did the mother have medical problems during the pregnancy? Yes_____ No_____

If yes, please describe, including medical attention:_____

Did the mother take medication during this pregnancy? Yes____No_____

If yes, what kind(s)?_____

Was the child full-term? Yes____ No___If no, what was the gestational age?_____

Were there complications during delivery? Yes_____ No_____ If yes, explain _____

_____

_____

Caesarian? Yes____ No____If yes, reason?_____

How long were the mother and child in the hospital?_____

Child's weight at birth?_____ Any birth injuries? Yes_____ No_____ If yes, explain _____

_____Was the child an RH baby?_____

What special medication attention or treatment did the child receive at birth, if any?_____

_____

MEDICAL HISTORY

Please list age, type of treatment, and/or number of recurrences next to those that apply.

ILLNESS	Age	Treatment	Recurrence	ILLNESS	Age	Treatment	Recurrence
Allergies				Ear Infections			
Asthma				Orthodontia			
Chronic colds				Seizures			
Dental problems				Tonsillitis			

Describe any other illnesses, accidents, injuries, and hospitalizations (include child's age).

_____

_____

_____

If child underwent any surgery, please describe (include date of surgery and surgeon's name).

_____

_____

_____

Child's health is good_____ fair_____ poor_____ Is the child now under medical treatment or on medication? Yes____No_____ If yes, please explain:_____

_____

_____

_____

MEDICAL EXAMINATION HISTORY

Month/year of last PHYSICAL EXAM_____Doctor_____

Results:_____

Month/year of last VISION TEST_____Doctor_____

Results:_____

Month/year of last HEARING TEST_____Doctor_____

Results:_____

Did/does child wear a hearing aid? Yes____No____Glasses? Yes_____No_____

If yes, explain:_____

_____

Dates of other pertinent medical examinations (e.g., neurological, psychological and ENT):

Date_____Doctor_____ Results:_____

_____

Date_____Doctor_____ Results:_____

_____

Date_____Doctor_____ Results:_____

_____

FEEDING HISTORY

Breast or bottle-fed?_____ If breast-fed, for how long?_____

Any difficulties transitioning from breast to bottle?_____Age when weaned off bottle_____

Were there any feeding difficulties during infancy Yes____ No_____If yes, describe_____

_____

_____

Weight after one year_____ Present weight_____

What age did your child begin puree foods (e.g., rice cereal, Stage 1 jarred)? _____

Soft chewables_____Table food_____

Did the child have difficulty transitioning to different food textures? Yes____ No____ If yes, explain:

_____

_____

Does your child have a limited diet due to "picky eating?" Yes_____ No_____If yes, describe:

_____

_____

_____

Does your child have any food allergies? Yes____ No____ If yes please list:_____

_____

_____

Does your child have any known gastrointestinal issues? Yes_____ No_____If yes, explain:

_____

_____

Check all that apply: Child finger feeds_____ uses fork_____spoon_____open cup_____straw_____

Is adult assistance needed with feeding? Yes____ No_____If yes, explain_____

_____

Has he/she ever choked on solid foods? Yes____ No____Does child cough on liquids? Yes_____ No_____

Can child chew well? Yes____No____Does he/she drool? Yes____ No____If yes, when? _____

DEVELOPMENTAL HISTORY

Did/does child use pacifier? Yes____ No____If yes, age weaned from pacifier_____

Does child continue to mouthe objects? Yes_____ No_____

Did/does child suck thumb/fingers? Yes_____ No_____If yes, until when? _____

Does child suck on hair/clothing/blanket/etc? Yes____ No____If yes, what?_____

Give ages at which the following first occurred:

Sat up_____Crawled_____Stood_____Walked_____ Ran_____

Bladder trained_____ Bowel trained_____Night trained _____

Which hand does the child use more frequently? Right_____Left_____No preference_____

Does child enjoy taking a bath? Yes_____ No_____Swings? Yes_____ No_____Parties? Yes_____ No_____

Rough housing? Yes_____ No____Does child resist tooth brushing? Yes____ No_____

Child prefers to primarily play alone_____with other children_____with older children_____with younger children_____with adults_____

Is child overly sensitive to loud sounds? Yes___ No___Bright lights? Yes____ No___Tags? Yes___ No____

Describe any OT or PT that the child is receiving/has received.

Type of Therapy	Therapist	Frequency	Place (Private/School)	Group or Individual?	Duration (e.g., age 3-5)

SPEECH, LANGUAGE AND HEARING DEVELOPMENT

Child babbled during the first 6 months? Yes___ No___At what age did child say first word?_____

What were the child's first words?_____

_____

Did the child keep adding words once he/she started to talk? Yes____ No____If no, explain:

_____

At what age did the child begin using 2 and 3 word phrases/sentences?_____

Did speech learning ever seem to stop for a period of time? Yes_____ No_____If yes, explain:

_____

Does your child talk a lot_____occasionally_____never_____

Does the child prefer to talk _____gesture_____talk and gesture_____

Does the child most frequently use sounds_____single words_____2-word sentences_____

3-word sentences_____ more than 3-word sentences_____

List examples:_____

_____

Does your child make sounds incorrectly? Yes____ No____If yes, which ones?_____

_____

Does your child hesitate, "get stuck," repeat or stutter on sounds or words? Yes___ No___If yes, describe:

_____

_____

Describe any recent changes in the child's speech:_____

_____

Can the child tell a simple story? Yes_____ No_____

How well is he/she be understood by the following individuals? (indicate "A" for all the time; "M" for most of the time; "S" for some of the time; or "R" for rarely)

Parents_____Siblings_____Teacher(s)_____Friends_____Strangers_____

Comments:_____

_____

Does the child seem to understand what you say to him or her? Yes____ No____If no, explain:

_____

_____

Does your child consistently answer to his/her name? Yes___ No___

Does your child make appropriate eye contact with adults? Yes___ No___Other children? Yes___ No____

Does your child follow simple commands? Yes____ No____ Please describe/give examples:

_____

_____

Does your child ever have trouble remembering what you have told him or her? Yes_____ No_____

If yes, explain?_____

_____

Does your child enjoy looking at books? Yes___ No___How often do you read to your child?_____

Describe any speech-language, hearing, feeding, or social skills therapy that the child is receiving/has received.

Therapist	Frequency	Place (Private/School)	Group or Individual?	Duration (e.g., age 3-5)

EDUCATIONAL HISTORY

Does your child attend? Daycare_____ Preschool_____ Kindergarten_____Grade School_____

Name of School _____ Grade/Level _____

In school, does he/she do: average _____below average _____above average _____work

What are the child's best subjects?_____

Has he or she repeated a grade? Yes_____No____If yes, which one(s)?_____

What is your impression of your child's learning abilities?_____

_____

_____

What is your impression of your child's social skills? _____

_____

_____

Does your child display any behavioral or attentional issues at school? _____

_____

_____

_____

Describe any psychological, special education services, tutoring that the child is receiving/has received.

Type of Service	Provider	Frequency	Place (Private/School)	Group or Individual?	Duration (e.g., age 3-5)