



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

PLEASE ATTACH A
 RECENT PHOTO OF YOUR
 CHILD HERE

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 _____

Child's Doctor: _____

Doctor's Address _____

Do you want a copy of our report sent to your child's doctor? Yes _____ No _____

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

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)