SPEECH PATHOLOGY DEPARTMENT
CASE HISTORY

Patient's Name: _____ Date: _____

Date of Birth: _____ Age: _____ Phone: _____/_____

Address: _____

Referred by: _____

Information Given By: _____ Relationship to Patient: _____

Explain Reason for Referral

_____

_____

Family History	Name	Age	Occupation	Address
Mother/Guardian	_____	____	_____	_____
Father/Guardian	_____	____	_____	_____
Children	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____

Has any relative of the child had a history of: (if yes, please list relationship and describe problem).

Speech problems _____ Learning problems _____

Stuttering _____ Cleft lip/palate_____

Hearing problems _____ Neurological problems _____

Other: _____

_____

Explain: _____

_____

BIRTH HISTORY

Did mother experience any illnesses or difficulties during this pregnancy? Explain:

_____

Medication taken during this pregnancy: _____

Length of: Pregnancy: _____ Baby's hospital stay: _____

Method of delivery (e.g., Caesarean) _____ Birth Weight: _____

Difficulties experienced during or following labor/delivery:

_____

MEDICAL HISTORY

Rate child's overall health: _____

List any hospitalizations, surgery, emergency care (explain): _____

_____

_____

Has child had any of the following: (indicate dates)

Head injury _____
Fainting/seizures _____
High fevers _____
Sleep disturbances _____
Vision problems _____
Hearing problems _____
Ear infections _____
Frequent colds _____
Chronic congestion _____
Allergies _____
Tonsils/Adenoid problems _____
Asthma _____
Other, explain: _____

_____

Medications your child has taken or been exposed to in past/present and reason:

_____

Does your child have a physical limitation? _____

Assistive devices used (e.g., wheelchair)? _____

DEVELOPMENTAL HISTORY

At what age did child do the following:

Sit alone _____ Crawl _____ Walk _____ Toilet train _____ Dress self _____ Ride bicycle _____

Do you have any concerns regarding your child's gross motor abilities?

_____

FEEDING HISTORY

Did child have sucking difficulties at birth? _____

Was child breast or bottle fed? _____ When was child weaned? _____

During feeding, did/does child have difficulty with:

Sucking _____
Food textures _____
Cup drinking _____
Handling utensils _____
Food tastes _____
Swallowing _____
Gagging/drooling _____
Choking/coughing _____
Chewing _____
Food temperatures _____
Spitting out/vomiting _____

Has your child received any testing due to feeding difficulty (e.g., video fluoroscopy)

_____

_____

When did child:

Transition from bottle to cup drinking: _____
Transition from baby to table foods: _____
Feed self independently with cup, utensils: _____
Any problems with positing: _____ Time for typical meal _____
Picky eating: _____ Food allergies: _____

SPEECH-LANGUAGE HISTORY (Fill out areas that apply to your child)

At what age did child begin to:

Babble: _____ Say first words: _____ Combine words: _____

Does child have difficulty with:

Hearing _____ Forming sentences _____
Following directions _____ Pronouncing sounds/words_____
Remembering _____ Stuttering _____
Vocabulary _____ Voice quality _____
Being understood by others_____
How much do you understand _____% Others not familiar with your child _____%

Explain above: _____
_____

Write down some examples of how child expresses himself: (e.g., dat a tup tate (that's a cupcake), me want daddy key), verbal or gestural:

_____
_____
_____

EDUCATIONAL HISTORY

Present school: _____Address:_____ Grade: _____

Describe child's adjustment/acceptance of school:

_____
_____

What school subjects does child:

Excel in: _____
Have difficulty with: _____

Does child's teacher describe problems with child's:

Behavior/cooperation: _____ Hearing: _____
Attention span: _____ Listening: _____
Learning: _____ Speaking: _____

Indicate evaluations performed with this child: (Please include date and place):

Child Study Team evaluation: _____
Speech/Language evaluation: _____
Hearing evaluation: _____
Psychological evaluation: _____
Neurological evaluation: _____
Physical Therapy evaluation: _____
Occupational Therapy evaluation: _____
Did/does child receive therapy or tutoring? (If yes, explain dates and place):_____
_____

BEHAVIOR

Describe child's:

Personality: _____
Attention span: _____
Best attention (list activities child likes): _____
Behavior problems: _____

Does your child exhibit the following?

Nervousness _____	Temper tantrums _____	Shyness _____
Over-activity _____	Daydreaming _____	Aggressiveness _____
Thumb sucking _____	Repetitive behaviors _____	Impulsiveness _____
Use pacifier _____		

How is your child best disciplined? _____
_____

Describe your child's play: What are your child's favorite play activities: _____
_____

List names and addreses to whom you would like evaluation results sent to:

_____
_____
_____
_____
_____

_____
_____