Skill Builders

Speech Language and Occupational Therapy Services

Case History Form

Person completing this form: _____ Date:_____

Relationship to child: _____

Insurance carrier: _____Referral Source:_____

PATIENT INFORMATION

Child's name: _____ Date of Birth:_____

Address:_____

Male / Female Age:_____ Grade:_____

FAMILY INFORMATION

Parent/Legal Guardian 1:_____ Date of Birth:_____

Occupation:_____ Work phone:_____

Address: _____

Parent/Legal Guardian 2:_____ Date of Birth:_____

Occupation:_____ Work Phone:_____

Address: _____

Sibling(s): _____ Age:_____

_____ Age:_____

_____ Age:_____

AREA OF CONCERN

Please describe the speech, language, voice, fluency, feeding, or learning areas that you are concerned with:

_____
_____
_____
_____
_____

When was the problem first noticed? _____

By whom was the problem first noticed? _____

Has your child received any previous help for the areas of concern? **YES** / **NO** (If yes, please list the type of help, dates of service, and the name of the professional or agency involved.)

1) _____

2) _____

3) _____

4) _____

Name of your child's pediatrician: _____

Address of the pediatrician: _____

_____

FAMILY HISTORY

Are there any family members or relatives who have or have had speech, language, voice, hearing, reading or writing difficulties? **YES** / **NO** (If yes please provide additional information)

_____
_____
_____
_____

Is any language other than English spoken in the home? **YES** / **NO** (If yes, please list all languages that are spoken)

_____
_____

By whom is/are the languages other than English spoken and how frequently?

_____
_____

PREGNANCY AND BIRTH HISTORY

Please check all that apply

Type of Complication	*1st Trimester*	*2nd Trimester*	*3rd Trimester*
Infectious/communicable	☐	☐	☐
Fall	☐	☐	☐
Auto accident	☐	☐	☐
Blood pressure	☐	☐	☐
X-Rays	☐	☐	☐
Surgeries	☐	☐	☐
Miscarriages	☐	☐	☐
Anemia	☐	☐	☐
Overweight	☐	☐	☐
Spotting	☐	☐	☐
Edema	☐	☐	☐
Hemorrhage	☐	☐	☐
Toxemia	☐	☐	☐
Any Drugs	☐	☐	☐
Any alcohol	☐	☐	☐
Other	☐	☐	☐

Was the baby full term?_____ If not, how early/late?_____

What was the length of labor?_____ Induced?_____ Cesarean?_____

What type of anesthesia? _____ Were forceps used? _____

Baby's weight/length?_____

Were there any complications during delivery? **YES** / **NO** (If your answer is "yes" please provide further explanation)

_____

_____

Did the baby require oxygen? _____

Was he/she jaundiced? _____

Were there any complications immediately following the birth or during the first few weeks of life:

☐ Difficulty Breathing	☐ Difficulty Sucking	☐ Difficulty Feeding
☐ Seizures	☐ Birth Defect	☐ Transfusions
☐ Extended Hospital Stay	☐ Jaundice	☐ Rubella Herpes
☐ Syphilis	☐ Sepsis	☐ Other (Please Specify)

Additional Comments:

_____

_____

_____

DEVELOPMENTAL HISTORY

Please check all that apply to your child:

Behavior	Yes	No	Approximate age the behavior started	Additional explanations
Cried less than normal	☐	☐		
Smiled less than normal	☐	☐		
Unusual crying sound	☐	☐		
Distracted during breast feeding	☐	☐		
Yelled/screamed to attract attention	☐	☐		
Rocking or banging of head	☐	☐		
Generally indifferent to sound	☐	☐		
Difficulty sucking	☐	☐		
Difficulty chewing	☐	☐		
Difficulty swallowing	☐	☐		
Preferred foods	☐	☐		
Excessive drooling	☐	☐		
Other:	☐	☐		

At what age did the following occur? (Please give your closest time approximation)

Held head up	_____	Weaned from bottle	_____
Rolled over back to stomach	_____	Ate from spoon	_____
Sat unsupported	_____	Drank from an open cup	_____
Crawled	_____	Ate lumpy/chopped food	_____
Walked unassisted	_____	Ate meat/solids	_____

FEEDING BEHAVIORS

Has your child had any feeding difficulties?

- ☐ Sucking or nursing
- ☐ Choking and / or gagging
- ☐ Regurgitation of liquids or solids through the nose
- ☐ Difficulty chewing or swallowing meats
- ☐ Excessive length of time to drink bottle

Does your child choke while eating? **YES** / **NO** (If "yes", on which foods?)

_____

_____

Is your child a picky eater? **YES** / **NO** (If "yes", what foods does he / she prefer?)

_____

_____

_____

Describe any feeding problems your baby experienced during the first 3 months of life.

_____

_____

_____

Does your child drool more than other children his / her age? **YES** / **NO**

Did your child have difficulty gaining weight as an infant? **YES** / **NO**

At what age did the following occur?

Expressive and Receptive milestones	Age	Additional info/explanation
Respond to own name		
Followed simple directions		
Recognized names of familiar objects		
Pointed to eyes, nose, and mouth when named		
Babbled		
Said first word		
Had a vocabulary of 10 words		
Combined two-words		
Talked in short sentences		
Said full name		
Verbally related events/experiences		

At the present time:

Does your child follow directions correctly? **YES / NO** (If your answer is "no" please provide further explanation of what your child does in place of this behavior)

_____
_____

Does your child respond to questions appropriately? **YES** / **NO** (If your answer is "no" please provide further explanation of what your child does in place of this behavior)

_____
_____

Do you need to use gestures? **YES** / **NO** (If your answer is "yes" please provide further explanation of what your child does in place of this behavior)

_____
_____

Do you need to repeat? **YES** / **NO** (If your answer is "yes" please provide further explanation of what your child does in place of this behavior)

_____
_____

Do you need to speak in short sentences? **YES** / **NO** (If your answer is "yes" please provide further explanation of what your child does in place of this behavior)

_____
_____

How does your child communicate his/her wants and needs?

_____
_____
_____

How much of your child's speech do you understand?

☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

How much of your child's speech do unfamiliar listeners understand?

☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Does a parent need to interpret for others? **YES** / **NO** (If your answer is "yes" please provide further explanation)

_____
_____

Does your child grope for words or use the wrong word? **YES** / **NO** (If your answer is "yes" please provide further explanation of his/her behavior)

_____
_____

Does your child repeat sounds or words previously heard? **YES** / **NO** (If your answer is "yes" please provide further explanation of his/her behavior)

_____
_____

Does your child's voice have a nasal or harsh quality? **YES** / **NO** (If your answer is "yes" please provide further explanation of his/her behavior)

_____
_____

Does your child seem to have adequate hearing? **YES** / **NO** (If your answer is "no" please provide further explanation of his/her behavior)

_____
_____

Has your child's hearing ever been tested? **YES** / **NO** If so where? _____

When? _____ Results of test: _____

MEDICAL HISTORY

	Age		Age
☐ Adenoidectomy		☐ High fevers	
☐ Allergies		☐ Influenza	
☐ Asthma		☐ Measles	
☐ Blood disease		☐ Meningitis	
☐ Chicken pox		☐ Mumps	
☐ Seizures		☐ Muscle disorder	
☐ Croup		☐ Nerve disorder	
☐ Dental problems		☐ Orthodontia	
☐ Diphtheria		☐ Pneumonia	
☐ Earaches		☐ Polio	
☐ Ear infections		☐ Rheumatic fever	
☐ Encephalitis		☐ Scarlet fever	
☐ Eye problems		☐ Tonsillectomy	
☐ Headaches		☐ Tonsillitis	
☐ Head injury		☐ Tuberculosis	
☐ Heart Problems		☐ Whooping cough	

Please describe any other serious illnesses, injuries or physical problems not mentioned above:

_____
_____
_____
_____

Does your child have any allergies? **YES** / **NO** (If your answer is "yes" please list all allergies)

_____
_____

Does your child take any medications? **YES** / **NO** (If your answer is "yes" please list all medications)

_____
_____

Has your child ever been hospitalized? **YES** / **NO** (If your answer is "yes" please provide further explanation)

_____
_____

SOCIAL / EMOTIONAL DEVELOPMENT

Please check all behaviors that you feel best describe your child:

- ☐ Overly active
- ☐ Overly quiet
- ☐ Destructive
- ☐ Perfectionist
- ☐ Outgoing
- ☐ Prefers older children
- ☐ Difficulty separating from parents
- ☐ Happy
- ☐ Defiant
- ☐ Easily controlled/passive
- ☐ Very shy
- ☐ Friendly
- ☐ Plays well with other children
- ☐ Prefers younger children
- ☐ Anxious
- ☐ Stubborn

SOCIAL BEHAVIOR

Which of the following describes the type of play your child likes to engage in most often?

- ☐ Putting toys in mouth
- ☐ Uses one object for another
- ☐ Does role playing
- ☐ Rough & tumble play
- ☐ Shaking toys
- ☐ Throwing toys
- ☐ Games with rules
- ☐ Make believe play
- ☐ Banging toys together
- ☐ Pushing / Pulling toys
- ☐ Acts out familiar routines
- ☐ Appropriate use of objects

What is the average length of time your child can stay playing at one activity? _____

What activities seem to hold your child's attention for the shortest period of time?

_____

_____

What activities seem to hold your child's attention for the longest period of time?

_____

_____

How does your child relate to you? _____

To your spouse? _____

To other children? _____

What is/are your child's preferred play activities? _____
_____
_____

Does your child avoid any play activities? **YES** / **NO** (If your answer is "yes" please provide further explanation of his/her behavior)
_____
_____

Is your child toilet trained? **YES** / **NO**

EDUCATIONAL HISTORY

Name of school your child is attending? _____

Name of his/her present teacher(s)? _____

Grade: _____ Full time? **YES** / **NO** (If your answer is "no" please list any other school(s) or daycare he/she attends, as well as how often)
_____
_____

What are your child's best subjects? _____

Worst subjects? _____

Does your child receive services from school? **YES** / **NO** (If yes please provide how often and by whom)
_____
_____

In scheduling your child's evaluation or therapy, is there any need for handicapped accessibility?

_____
_____

Other pertinent information or comments:

_____
_____
_____
_____

*Please provide copies of any pertinent assessments, reports, and/or records prior to your child's first appointment. **THANK YOU!**