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CASE HISTORY

Name _____ DOB _____ Age _____

Sex _____ Race (optional) _____

Referred by _____

Address _____
Street City State Zip

Preferred Phone _____ Alternate Phone _____

Email _____

Family Physician _____ Address _____

Father's Name _____ Age _____

Address _____ Home Phone _____

Occupation _____ Employer _____

Marital status _____ Education _____

Mother's Name _____ Age _____

Address _____ Home Phone _____

Occupation _____ Employer _____

Marital status _____ Education _____

List names and ages of child's sisters and brothers _____

Relationships and ages of others living in the home _____

Insurance Information

Medical Insurance Company _____

Address _____
Street City State Zip

Group or Policy # _____ Name of Policy Holder _____

Policy Holder's ID #: _____ Date of Birth: _____

Statement of the Problem

Describe the problem: _____

When the problem was first noticed: _____

Describe how you and others in the family react to this problem _____

What do you think causes this problem? _____

Describe what has been done about it- when and where: _____

General Development

PREGNANCY

Mother's state of health: _____

Length of pregnancy: _____ Medications Taken: _____

Difficulties during pregnancies: _____

Miscarriages or stillborns: _____ Number of living children: _____

DELIVERY

Hours of labor: _____ Was labor induced _____

Complications: _____

Type of Delivery: Normal _____ Instrument _____ Breech _____ Caesarean _____

Drugs or Anesthesia used: _____

Single or Multiple Birth: _____

CONDITION AT BIRTH

Full term: _____ Premature: _____ Jaundiced: _____ Bleeding: _____ RH Factor _____ Breathing

Difficulties: _____

Birth Weight: _____ Length: _____ Age at discharge from nursery _____

Evidence of birth injury: _____

Congenital Birth Defects: _____

Health during first weeks of life: _____

Comments: _____

DEVELOPMENTAL

AT what age did the child:

Sit alone: _____ Crawl: _____ Stand alone: _____ Walk: _____

Feed Self: _____ Drink from a cup: _____ Bowel control: _____

Bladder control: _____ Dress self: _____

Was the child bottle or breast fed: _____ Age when weaned: _____
Any feeding problems: _____
Does your child choke while eating? _____ On what foods? _____
Does your child suck his/her thumb? _____ Does your child trip or stumble often? _____
Does the child drool? _____

MEDICAL HISTORY

Describe any unusual diseases or surgery: _____

Describe any serious illnesses, accidents, or high fevers: _____

Earaches or ear infections: _____

Does your child have frequent coughs, colds, sinus congestion, and/or respiratory infections? _____

List any medication your child is currently taking and why:

Who is your child's pediatrician? _____

List of any known allergies and to what: _____

Have ears been tested: _____ When: _____ By whom: _____

Results: _____

Do you think your child hears adequately? _____

Does your child's hearing appear constant or variable? _____

Does your child's hearing worsen when he/she has a cold? _____

PREVIOUS EVALUATIONS AND/OR TREATMENT

Has your child ever been evaluated and/or treated for hearing, vision, speech-language motor, seizure, behavior, emotional, or learning problems: _____

Dates: _____ By whom: _____

Type of evaluation and/or treatment: _____

Results and/or recommendations:

SPEECH-LANGUAGE HISTORY

Did your child make babbling and cooing sounds during first six months? _____

Age at which your child spoke single words: _____

Two-word phrases: _____ Spoke so the family could understand him/her _____

Age at which a speech-language problem was first suspected: _____

Does your child follow simple directions such as "Get me the ball?" _____

Is your child aware of the problem? _____

Does your child's speech pattern cause him/her to be shy, withdrawn or maladjusted? _____

Are there any known defects of the child's tongue, palate, nose, throat, ears, lips, or teeth? _____

Are there any family members with speech, language, or hearing problems? _____

What is the primary language spoken in the home? _____

Are there any other languages spoken in the home? _____ Does your child
enjoy speaking? _____ Does your child enjoy playing with other children? _____

Current grade, school and district child is enrolled in: _____

This form was completed by: _____

Relationship to patient: _____