Beyond Words

a creative approach to pediatric speech and language therapy

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CASE HISTORY FORM

The information you provide on this form will not be released without your consent. Please complete all information requested.

Date completed _____

Completed by _____ Relationship to child _____

How was child referred to this therapist?_____

Days and times available for therapy_____

_____

Insurance _____

Insured member ID _____

Insured address _____

Clients relationship to insured _____

CLIENT INFORMATION

Child's Name _____ Date of Birth _____

Address_____

Gender_____

List any languages your child has been exposed to _____

_____

Topics and activities of high interest that may be helpful for therapy/ planning_____

FAMILY INFORMATION

Mother's Name _____Phone _____

Address_____

Father's Name _____Phone_____

Address_____

Sibling(s) Name(s) and Age(s) _____

_____

CONCERNS

What is your main concern regarding your child at this time? _____

_____

_____

When and **how** was the problem first noticed? _____

_____

Has your child received intervention or support for your area of concern? _____ If yes, please list the type of support, dates of service and the name of the professional or agency involved _____

_____

Primary Care Physician_____

Phone_____

Address_____

Other Doctors seen (name and specialty) _____

_____

Do any family members or relatives have/had speech, language, voice, stuttering, or learning difficulties? _____ If yes, please describe_____

_____

MEDICAL HISTORY

Was your child born at full term?_____ If not, how early or late? _____

_____

Were there any complications during delivery? _____ If yes, please provide further explanation_____

How is your child's general health _____

_____

Any known syndrome or diagnosis?_____

_____

Please describe any serious illnesses, injuries or physical problems your child has experienced:_____

_____

Please name any medications your child takes on a regular basis_____

_____

Does/did your child experience any of the following: (Please check all that apply)

High fevers:_____ Frequent sore throats:_____

Sinus Infections:_____ Short frenum:_____

Nasal airway difficulties_____

Large tonsils/adenoids:_____ Large tongue:_____

Allergies?_____ If yes, please list allergies_____

_____

Has your child been hospitalized?_____ If yes, when and why?_____

_____

Is your child toilet trained?_____

Does your child wear glasses? _____ If yes, what for_____

Is there anything else about your child's medical history that is important to know prior to beginning speech and language therapy?

_____

_____

_____

HEARING HISTORY

Has your child's hearing been tested? _____ If yes, where and when?

_____

Results _____

Does your child have a history of ear infections?_____ If yes,explain

_____

How are your child's ear infections treated? _____

Does your child have a history of impacted ear wax?_____

Has your child been seen by an Ear Nose and Throat Doctor? _____

_____

Has your child had surgery on his/her ears?_____

If so, what kind of surgery and when?_____

Does/did your child wear hearing aids?_____ If yes, which ear/ears?_____

SPEECH AND LANGUAGE HISTORY

Give ages when child:

Spoke first words_____ Knew their name_____ Responded to "no"_____

Understood word "bye"_____ Followed 1step directions_____

Recognized names of familiar objects_____ Put 2 words together_____

Answered "yes" or "no" questions _____

How does your child show that he/she understands what you say _____

_____

Describe how your child lets you know what he/she wants or needs

_____

Does your child recognize his/her communication difficulties?_____ If yes,

please describe_____

List three sample sentences, phrases, or words your child now uses _____

_____

Approximately how much of what your child says do you understand (give p

percentage)?_____

Approximately how much of what your child says do unfamiliar listeners understand (percentage)? _____

Are sounds omitted?_____

Is one sound substituted for another?_____

Does your child grope for words or use the wrong word?_____ If yes, please provide explain_____

_____

Does your child repeat sounds or words previously heard?_____ If yes, please explain _____

Any concerns regarding your child's voice?_____

MOTOR DEVELOPMENT

Give ages when your child:

Crawled?_____ Walked alone?_____ Ate solid foods?_____

Drank from a cup?_____ Dressed self?_____ Feed self?_____

Was your child breast fed? _____

If yes, how long?_____Bottle fed?____ If yes, how long?_____

Any problems with breast or bottle feeding? If so, please explain _____

_____

Please check any feeding difficulties your child has now, or had in the past: _____ sucking _____ chewing _____ choking

_____ swallowing _____ accepting new foods _____ drooling

_____ strong dislikes for certain foods or textures

Did/does your child suck their thumb, fingers, or pacifier? If yes, please explain when the sucking occurs/occurred and for how long _____

_____

How is your child's overall physical coordination?_____

EDUCATIONAL HISTORY

Name of school(s) your child attends_____

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

_____ Grade: _____

Full time? _____ If no, please list any other school(s) or daycare he/she attends_____

_____

Does your child receive services from school? _____ If yes, please provide how often and by whom_____

_____

_____

Other pertinent information or comments_____

_____

_____

SOCIAL/ BEHAVIORAL INFORMATION

What is/are your child's preferred activities?

_____

How does your child interact with others?_____

Does your child avoid any activities?_____ If yes, please provide further explanation_____

_____

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? _____

Special Services (IFSP/IEP)?_____

PLEASE PROVIDE ANY COPIES OF RELEVANT EVALUATIONS, REPORTS AND/OR RECORDS AT YOUR CHILDS INITIAL APPOINTMENT