

Pediatric Speech-Language Case History

Child's Name: _____ Birthdate: __/__/____

Doctor's Name: _____ Doctor's Phone: _____

Referral Source (if different than regular doctor): _____

Name of person completing this form: _____

Relationship to patient: _____

Primary caregiver's name and preferred phone number: _____

Social Environment

1. Child lives with: both parents mother father siblings

2. Child's primary language:

3. Any other languages spoken in the home:

4. Name of school and current grade:

5. Any problems or concerns at school?

Speech/Language Concerns

1. Do you feel the child has difficulty communicating? Y N

If yes, please describe in detail: _____

2. When did the communication difficulties begin? _____

3. Has the child had a hearing test? Y N

If yes, when was the test and what were the findings? _____

4. Has the child ever had a speech/language evaluation? Y N

If yes, when and where was the evaluation? _____

What were the findings? _____

5. Has the child ever received speech/language therapy? Y N

If yes, when and how long was the course of treatment? _____

6. Are there any other concerns about the child's development? Y N

If yes, please describe: _____

7. Does the child exhibit any physical or emotional difficulties? Y N

If yes, please describe: _____

8. Does the child become agitated or frustrated because of lack of communication skills? Y N

9. Please describe any other behavioral issues: _____

Birth History

1. Was the pregnancy free of complications? Y N

If no, please describe: _____

2. Was the child born full-term? Y N

If no, how many weeks? _____

Please describe any issues or concerns: _____

3. Was the child discharged with the mother? Y N

If not, please describe why and the length of hospital stay: _____

4. What was the mother's age when the child was born? _____

Medical History

1. Has the child had any of the following?

adenoidectomy tonsillectomy allergies asthma

sleeping difficulties/snoring ear infections ear tubes

thumb sucking habit seizures head injury complications at birth

Please describe in detail any other issues you feel are pertinent to today's visit. _____

2. Please describe any other serious injury/surgery/hospitalization/ongoing medical conditions: _____

3. Please list any known allergies: _____

4. Please list any medications the child takes regularly: _____

5. Please list any other physicians or therapists involved in your child's care: _____

Developmental History

1. Please give the approximate age the child achieved the following milestones:

_____ sat alone _____ walked _____ babbled _____ said first words

_____ put two words together _____ spoke in short sentences

2. Does the child:

Y N understand you?

Y N follow simple directions?

Y N make wants/needs known using words?

Y N respond appropriately to yes/no questions?

Y N communicate with gestures?

Y N become frustrated easily?

3. Has the child demonstrated difficulty suckling or transitioning to solid foods? Y N

If yes, please describe _____

4. Has the child demonstrated difficulty swallowing? Y N

If yes, please complete the Swallowing History form.