40 Willard St.
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PEDIATRIC CASE HISTORY

IDENTIFYING AND FAMILY INFORMATION

Child's Name: _____ Date of Birth: _____

Gender: ____ M _____ F

Mother's Name: _____ Cell Phone: _____

Address: _____ Home Phone: _____

_____ E-Mail: _____

_____

Father's Name: _____ Cell Phone: _____

Address: _____ Home Phone: _____

_____ E-Mail: _____

_____

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

Other Children In the Family:

Name	Age	Sex	Grade	Speech/Hearing Problems

_____

_____

_____

Child's race/ethnic group:

___ Caucasian, Non-Hispanic ___ Hispanic ___ African-American
___ Native American ___ Asian or Pacific Islander ___ Other _____

Is there a language other than English spoken in the home? ____ Yes ____ No
If yes, which one? _____
Does your child speak the language? ____ Yes ____ No
Does the child understand the language? ____ Yes ____ No
Who speaks the language? _____
Which language does the child prefer to speak at home? _____

SPEECH-LANGUAGE-HEARING

Do you feel your child has a speech problem? ___ Yes ___ No
If yes, please describe. _____

_____

_____

Do you feel your child has a hearing problem? ___ Yes ___ No
If yes, please describe. _____

_____

_____

Has he/she ever had a hearing evaluation/screening? ___ Yes ___ No
If yes, where and when? _____
What were you told? _____

_____

_____

Has your child ever had speech therapy? ___ Yes ___ No

If yes, when and where? _____

What was he/she working on? _____

_____

_____

Has your child received any other evaluation or therapy (physical therapy, occupational therapy, counseling, vision etc.)? ___ Yes ___ No

If yes, please describe. _____

_____

_____

_____

Is your child aware of, or frustrated by any speech/language difficulties? _____

_____

What do you see as your child's most difficult problem in the home? In the school?

_____

BIRTH HISTORY

Was there any complications surrounding the pregnancy or birth? ____ Yes ____ No

If yes, please describe. _____

_____

How old was the mother when the child was born? _____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ____ Yes ____ No

If the child stayed in the hospital, please describe why and for how long. _____

_____

_____

MEDICAL HISTORY

Has your child had any of the following?

___ adenoidectomy
___ allergies
___ breathing difficulties
___ chicken pox
___ colds
___ear infections
How often? _____
___ ear tubes
___ encephalitis
___ flu
___ head injury
___ high fevers
___ measles
___ meningitis
___ mumps
___ scarlet fever
___ seizures
___ sinusitis
___ sleeping difficulties
___thumb/finger sucking
___ tonsillectomy
___ tonsillitis
___ vision problems

Other serious injury/surgery: _____

Is your child currently under a physician's care? ___ Yes ___ No
If yes, why? _____

_____

Please list any medications that your child takes regularly: _____

_____

_____

DEVELOPMENTAL HISTORY

Please provide the approximate age your child reached the following developmental milestones:

_____ sat alone
_____ babbled
_____ put two words together
_____ walked
_____ grasped crayon/pencil
_____ said first words
_____ spoke in short sentences
_____ toilet trained

Does your child do any of the following?

_____ Choke on food or liquids?
_____ currently put toys/objects in his/her mouth?
_____ brush his/her teeth and/or allow brushing?

CURRENT SPEECH-LANGUAGE AND HEARING

Does your child……

____ repeat sounds, words, or phrases over and over?
____ understand what you are saying?
____ retrieve/point to common objects upon request (ball, cup, shoe)?
____ follow simple directions ("Shut the door" or "Get your shoes")?
____ respond correctly to yes/no questions?
____ respond correctly to who/what/where/when/why questions?

Your child currently communicates using……

____ body language
____ sounds (vowels, grunting)
____ words (shoe, doggy, up)
____ 2 to 4 word sentences
____ sentences longer than 4 words
____ Other _____

Behavioral Characteristics:

____ cooperative
____ attentive
____ willing to try new activities
____ willing to play alone
____ separation difficulties
____ easily frustrated/impulsive
____ stubborn
____ restless
____ poor eye contact
____ easily distracted/short attention
____ destructive/aggressive
____ withdrawn
____ inappropriate behavior
____ self-abusive behavior

SCHOOL HISTORY

If your child is in school, please answer the following:

Name of school and grade: _____

Teacher's Name: _____

Has your child repeated a grade? _____

What are your child's strengths and/or best subjects? _____

_____

Is your child having any difficulty with any subjects? _____

_____

Is your child receiving help in any subject areas? _____

_____

Has your child had any difficulty making friends and/or maintaining relationships with peers? _____

_____

ADDITIONAL COMMENTS: _____

_____

_____

_____

_____