SPEECH/LANGUAGE CASE HISTORY

PATIENT INFORMATION *Referred by:* ________________________________

Child's Name: _______________________________________ DOB: _______________ Age: _____ **M / F**

Parent/Caregiver 1 NAME______________________________ DOB___________ Occupation __________________

Parent/Caregiver 2 NAME______________________________ DOB___________ Occupation __________________

Address: _____________________________ Address (if different):__________________________

City/State/Zip: ________________________ City/State/Zip: _______________________________

Home Phone: _________________________ Home Phone: ________________________________

Cell Phone: ___________________________ Cell Phone: __________________________________

Email Address: ________________________________

Primary Care Physician/Pediatrician: ______________________________________ Phone_____________________

Other Special Services (i.e., IEP, other therapies, etc.): **Y / N** *If yes, explain:*

____

____

Language(s) Spoken at Home: ________________________________ Preferred Language: ____________

AREA OF CONCERN(S)

Describe the concerns you have about the child's communication skills at this time: __________________________

____

____

Are there any skills your child had learned previously, but can no longer use? Describe:_______________________

____

What are your goals for therapy? ____

____

BIRTH HISTORY

Adopted? **Y / N** (*circle) - If Yes, at what age? From where?* ___________________________ Foster? **Y / N** *(circle)*

Full Term / Premature (# weeks early: _______) Complications: ______________________________

NICU Stay (if yes, how long?): _____________ Delivery Type: Vaginal / C-Section

Birth Weight: ________________ Mother's Gestational Health (describe)___________________

Drugs/Alcohol/Medication consumed during pregnancy? **Y / N** (*circle) - If Yes, explain:* __________________________

MEDICAL INFORMATION

Medical Diagnoses (*check all that apply):*

☐ ADHD ☐ Autism ☐ Cerebral Palsy ☐Down Syndrome ☐Dyslexia
☐ Anxiety ☐ Learning Disorder ☐ Sensory Processing ☐ Genetic Condition (explain)
☐ Other (*explain*):____

SPEECH/LANGUAGE CASE HISTORY

Has hearing been tested? **Y / N** When? __________ Where? ______________ Results________________________

Medications(& dosage/how often): ____

Surgeries/Hospitalizations (date):____

List any Allergies/Precautions:____ ☐ No Known Allergies

Has your child experienced any of the following (check all that apply)
□ Frequent Colds □ Seizures □ Mouth Breathing
□ Sleeping Problems □ Frequent Ear Infections □ Snoring
□ Other:

Have there ever been any concerns with feeding? (*Problems with sucking/swallowing/drooling/chewing/etc?)* **Y / N**
*If yes explain:*____

Has your child seen/currently seeing any of the following specialists? (check all that apply)

Past	Current		Past	Current	
☐	☐	Occupational Therapist	☐	☐	Ear, Nose, Throat Specialist
☐	☐	Physical Therapist	☐	☐	Audiologist
☐	☐	Speech Therapist	☐	☐	Ophthalmologist/Vision Specialist
☐	☐	Psychologist	☐	☐	Neurologist
☐	☐	Other:			

Does your child currently or have history of using any special equipment? Check if applicable:
☐ Glasses/Contact Lenses ☐ Communication Device ☐ Hearing Aids
☐ Braces ☐ Retainer ☐ Palatal Expander ☐Other:

DEVELOPMENTAL HISTORY

Please write the approximate age that your child acquired the following skills ***(if you can't remember the exact age, please indicate/check the box that best describes when he/she achieved this skill compared to their peers)***

Skill	AGE	*Earlier Than Peers*	*Same as Peers*	*Later Than Peers*	*N/A*
Sit					
Roll Over					
Crawl					
Stand					
Walk					
Feed Self					

SPEECH/LANGUAGE/COMMUNICATION HISTORY:

Please write the approximate age that your child acquired the following skills ***(if you can't remember the exact age, please indicate/check the box that best describes when he/she achieved this skill compared to their peers)***

Skill	AGE	*Earlier Than Peers*	*Same as Peers*	*Later Than Peers*	*N/A*
Babbling (i.e., ba ba ba)					
Used First Word					
Combined 2-3 Words Together					
Make a Sentence					
Put 2+ Sentences Together					
Engage in Conversation					

Child's first word(s): ____

How many words does your child currently use? __________ *List if less than 15 words (if possible):*

SPEECH/LANGUAGE CASE HISTORY

Does your child currently: (check all that apply)
□ Follow directions check all that apply): □ 1-step directions □ 2-step directions □ 3+ step directions
☐ Point (*to objects/pictures/body parts/etc.)* ☐ Respond to their name consistently

Which of the following describes how your child communicates: (check all that apply)
□ Pointing/gesturing □ non-specific vocalizations □ Eye-contact/facial expressions □ Sign Lang.
□ Single Words □ Short Phrases □ Sentences
☐ Guiding/pulling person to desired object ☐ Other (explain): ___________________________

In what situations does your child have most difficulty communicating?: (check all that apply)
☐ Home ☐ Daycare/Preschool ☐ School ☐ With Friends ☐ Everywhere

Do you have difficulty understanding his/her speech? **Y / N**
About how much of what he/she says do you understand? ☐ 0-25% ☐ 25-5 0% ☐ 50-75% ☐ 75-100%

Do others have difficulties understanding his/her speech? **Y / N**
About how much of what he/she says do you think they understand? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%

What does your child do when they are not understood? Please explain (*i.e., repeats or modifies message, gives up, becomes aggressive, etc.)*

SOCIAL-EMOTIONAL HISTORY:
Please Check All That Apply to Your Child Below:

Behaviors		Temperament
☐ Difficulty with transitions	☐ Enjoys company of other kids	☐ Friendly
☐ Unusually Quiet	☐ Prefers to Play Alone	☐ Cooperative
☐ Easily Upset	☐ Rocks his/her Body	☐ Shy
☐ Enjoying "Messy" Play	☐ Restless/Fidgety/Can't Sit Still	☐ Calm
☐ Bumping/Pushing Others	☐ Upset with Loud Sounds	☐ Stubborn
☐ Biting/Hitting Others	☐ Strongly Dislikes Being "dirty"	☐ Tantrums Often
☐ Biting/Hitting/Hurting Themself		☐ Other (explain):
☐ Easily Distracted		
☐ Impulsive and/or Unsafe		
☐ Understands Personal Safety		
☐ OTHER (explain):		

Do you have concerns with any of his/her behavior? **Y / N** ____

FAMILY BACKGROUND:

Name (s) of ALL Individual's Living With the Child	Relationship	Age	Sex

Have any family members had any speech/language, hearing problems, and/or learning difficulties? (circle) **Y / N**

If yes - explain: ____

SPEECH/LANGUAGE CASE HISTORY

EDUCATIONAL INFORMATION:

Is your child currently enrolled / attending:
☐ Daycare ☐ Preschool ☐ Head Start ☐ School ☐ Other:______________________

Where? ____ Number of Hours Per Week: _____________________

How is your child performing in the program? ____

Does your child receive any special services at school (i.e., IEP, 504, etc.)? **Y / N** *(if yes, explain):* _________________

____

ADDITIONAL INFORMATION:

What do you feel your child's strengths are? ____

____

Is there any other information that you would like to share that you feel would be beneficial? __________________

____

Thank you for taking the time to complete your child's history form. We look forward to working with your family and thank you for choosing Holly Springs Feeding and Speech to help meet your child's needs.

Parent/Guardian Signature: ___________________________________ Date: ___________________