SMALL TALK
pediatric speech therapy

CASE HISTORY FORM

Date:_____

Person completing form: _____ Relationship to child: _____

Insurance carrier: _____ Referral Source:_____

Preferred email for correspondence: _____

Emergency Contact: _____ Phone #:_____

PATIENT INFORMATION:

Child's name: _____ Date of Birth:_____

Address:_____

Male / Female: _____ Age: _____

Any current diagnoses: _____

Client's Physician and Practice: _____

Address: _____ Phone: _____

FAMILY INFORMATION:

Mother's name:_____ Date of Birth:_____
Occupation:_____ Phone Number:_____
Address: _____

Father's name:_____ Date of Birth:_____
Occupation:_____ Phone Number:_____
Address: _____

Sibling(s):

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any family history of speech, language, hearing, or learning difficulties _____

_____

Language(s) spoken in the home: _____

By whom: _____ Does child understand: _____

Any additional information regarding the home environment that might be helpful: _____

_____

AREA OF CONCERN: Please describe the areas you are concerned with:

_____

_____

_____

When and by whom was the problem first noticed: _____

How does child's communication issue impact the family: _____

_____

Is child aware of or frustrated by the communication difficulty: _____

Has your child received or is currently receiving any of the following services:

	Name	Last Date of Service
Developmental Pediatrician	_____	_____
Neurologist	_____	_____
PT	_____	_____
OT	_____	_____
SLP	_____	_____
Behavioral Therapist	_____	_____
Educational Consultant	_____	_____
Psychologist/Psychiatrist/Counselor	_____	_____
Vision Therapist	_____	_____
Other	_____	_____

PREGNANCY AND BIRTH HISTORY:

Anything unusual about the pregnancy (ie: illness, infection, injury, complications, stress, drugs, alcohol):

_____

_____

Mother's age at birth: _____ How many weeks gestation at birth: _____

Induced: _____ Cesarean _____ Were forceps used _____ Baby's weight/length?_____

Were there any complications during labor/delivery: _____
_____
_____

Were there any complications immediately following the birth or during the first few weeks of life:

_____ Breathing Problem	_____ Seizures	_____ NICU	_____ Herpes
_____ Difficulty Sucking	_____ Birth Defect	_____ Jaundice	_____ Syphilis
_____ Difficulty Feeding	_____ Transfusion	_____ Rubella	_____ Sepsis

If any checked, please explain: _____

_____

MEDICAL HISTORY:

Please check if your child has had any of the following:

_____ Adenoidectomy	_____ Diabetes	_____ Pneumonia
_____ Allergies	_____ Ear Infections/tubes	_____ Seizures
_____ Asthma	_____ Encephalitis	_____ Sensory Issues
_____ Behavioral Issues	_____ Frequent Colds	_____ Sleep Issues
_____ Brain Injury	_____ Hearing Loss	_____ Tongue Tie
_____ Breathing Problems	_____ High Fevers	_____ Tonsillectomy
_____ Cardiac Issues	_____ Measles/Mumps/Rubella	_____ Tonsillitis
_____ Chicken Pox	_____ Meningitis	_____ Vision Issues

If any checked, please explain: _____

_____

Any concern regarding child's hearing: _____

Has your child's hearing ever been tested: _____ By Whom: _____

Result: _____

Other serious illness/injury: _____

Hospitalization: _____

Surgery: _____

Medication: _____

Is your child current with immunizations: ____ Describe if NO: _____

_____

SPEECH and LANGUAGE DEVELOPMENT:

At what age did the following occur? Use best estimate. It's ok if you can't remember exact ages.

Expressive and Receptive Milestones	*Age*	*Additional Info/Explanation*
Respond to own name	_____	_____
Followed simple directions	_____	_____
Recognized names of familiar objects	_____	_____
Pointed to eyes, nose, and mouth when named	_____	_____
Babbled	_____	_____
Said first word	_____	_____
Had a vocabulary of 10 words	_____	_____
Combined two-words	_____	_____
Talked in short sentences	_____	_____
Verbally related events/experiences	_____	_____

At the present time:

How does your child communicate his/her wants and needs (gestures, words, both, neither): _____

_____

How many words does your child say (range is ok): _____

Does your child:

_____ Repeat sounds, words, phrases
_____ Understand what you are saying
_____ Retrieve/point to object on request
_____ Identify objects
_____ Identify actions in a book
_____ Follow directions consistently
_____ Respond correctly to Y/N questions
_____ Respond to WH (who, what, etc) questions

SPEECH DEVELOPMENT:

How much of your child's speech do you understand? 10% 25% 50% 75% 100%

How much of your child's speech do unfamiliar listeners understand? 10% 25% 50% 75% 100%

Does a parent need to interpret for others: _____

Does your child grope for words or use the wrong word: _____

Does your child repeat sounds or words previously heard: _____

Does your child's voice have a nasal or harsh quality: _____

FEEDING and ORAL MOTOR DEVELOPMENT:

Does your child do any of the following:

_____ Use pacifier/thumb/finger suck
_____ Mouth objects
_____ Eat table food
_____ Avoid food or textures
_____ Drink from a cup/straw
_____ Use spoon/fork
_____ Choke, cough, or gag with liquids
_____ Choke, cough, or gag with solids

Additional information or concerns regarding your child's eating: _____

_____

SOCIAL and BEHAVIORAL DEVELOPMENT:

Please check the behavioral characteristics that apply to your child:

_____ Cooperative
_____ Attentive
_____ Willingness to try new things
_____ Plays alone for a reasonable time period
_____ Difficulty with transitions
_____ Destructive/aggressive
_____ Inappropriate behavior
_____ Separation difficulties
_____ Easily frustrated/impulsive
_____ Stubborn
_____ Poor eye contact
_____ Easily distracted/short attention
_____ Withdrawn
_____ Self-abusive behavior

What is/are your child's preferred play activities? _____
_____
_____

Is your child toilet trained: _____

What are your child's strengths: _____

_____

What are your child's weaknesses: _____

_____

EDUCATIONAL HISTORY:

Name of school and teachers: _____

Days and times child is at school: _____

Does your child receive services from school: _____

If yes please provide how often and by whom: _____
_____

Other pertinent information or comments:

_____
_____
_____
_____
_____

*Please provide copies of any pertinent assessments, reports, and/or records prior to your child's first appointment. THANK YOU!