The Speech, Language & Learning Center, LLC

Pediatric Case History

The information that you provide to us on this case history form will be strictly confidential. Please answer all questions as completely as possible. Gathering information about medical history, education, development and family is a very important step in determining whether or not there is a communication deficit. A detailed case history will allow us to better evaluate your child. Use the back of this form to provide detailed responses if necessary.

Person completing this form: _____
Relationship to the child: _____
Date of the Evaluation: _____
Place of the Evaluation: _____

Child's Name: _____
Birthdate: _____ Age: _____ yrs. _____ mos.

Parents: (check one)
Married ___ Divorced ___ Single ___ Separated ____ Deceased ___
Foster parent ___ Legal Guardian ___

Mother's Name: _____
Address: _____
_____
Home Phone: _____ Cell Phone: _____
Work Place: _____
Work Phone: _____
Email address: _____
Do you check email at least one time a week? _____

Father's Name: _____
Address (if different): _____
_____
Home Phone (if different): _____ Cell Phone: _____
Work Place: _____
Work Phone: _____
Email address: _____
Do you check email at least one time a week? _____

Who referred you to our Center? _____

Has your child been tested anywhere before coming here? _____
_____
_____
Do we have your permission to have records released from other sources? _____
Please give us their name and address or send copies of previous reports from other professionals attached to this form. _____
_____
_____

Please describe, in your own words, your concerns about your child and why you are having this evaluation completed: _____
_____
_____
_____

Medical History

Pregnancy:
Birth order for this child? _____ out of _____ children
Did you have any unusual problems during pregnancy? _____ Please describe:
_____
_____
Bleeding? ____ Drugs? _____ Falls? _____ Accidents? _____ Surgery? _____
(if you answered 'yes' to any of these questions, please describe on the back page of this questionnaire.)

Delivery:
Did you carry this child to term? _____ If the baby was premature, how many weeks did you carry him/her? _____ (Please explain any problems on the back page of this form.)
Birth Weight: _____ Breech? _____ Caesarian? _____
Where was the child born? _____
Who delivered your child? _____
Did your child require an extended hospital stay after birth? _____
_____
_____
(please give details on back of this page)

Illnesses

Has your child ever been hospitalized? _____ Please describe any severe illnesses or injuries? _____
_____
_____
_____

Does your child have a history of:
Heart Disease? _____ Asthma? _____ Diabetes? _____
Allergies: _____ Please list: _____
Ear infections? _____ PE Tubes? _____ When? _____
Tonsils or Adenoids removed? _____ When? _____
Who was the ENT? _____
Hearing tested? _____ Where? _____
Results: _____

Vision tested? _____ Where? _____
Results: _____

Who is your child's pediatrician or primary care physician? _____
Address: _____
Phone: _____

Does your child see other doctor's as Specialists? _____ If so, please list all names, specialty areas and contact information on the back of this form.

Developmental History

Feeding:

Was your child breast fed? _____ If so, how long? _____
Was your child bottle fed? ____ If so, how long? _____

Did your child transition easily from breast to bottle? yes no NA
Did your child transition easily from bottle to sippy cup? yes no NA

At what age did your child begin to eat baby foods or cereal? _____

Did your child have any problems with early feeding/eating/swallowing? _____
If so, please describe: _____
_____
_____
(use the back of this page if needed)

Does your child presently have any of the following problems while eating:
Excessive drooling? yes no
Chewing? yes no
Swallowing? yes no
Choking? yes no
Using a sippy cup? yes no
Using a regular cup? yes no
Using a spoon? yes no
Is your child a picky eater? yes no
Please list his/her preferred foods: _____
_____
Please list the things that he/she will not eat: _____
_____
Did/Does your child suck fingers, thumb, pacifier? _____ How long? _____
Does your child have normal dentition? _____ If not, explain:
_____

If we are evaluating your child for a feeding problem:

- What have you been told about your child's problem and by whom?

- What is <u>your</u> idea about your child's feeding problem?

- How do you think we can most help you?

<u>Sleeping:</u>
Does your child take regular naps? _____ How long does he/she nap? _____
Does he/she have a regular bedtime? _____ What time? _____
My child sleeps: _____ alone _____ with me _____ with a sister or brother
Does your child sleep through the night? _____ Please describe any sleeping habits: _____

<u>Motor and Social Development:</u>
At what age did your child:
sit up alone: _____
walk: _____
toilet train: _____
climb stairs: _____
Which hand does your child primarily use: Right or Left

Does you child attend daycare or preschool? _____ How often? _____
Where? _____

Is your child enrolled in school? _____ Where? _____
What grade? _____ Teacher: _____
Has your child repeated an grades? _____ Which one(s)? _____
Has your child ever been referred for special education/resource testing or placement in a special education program? _____
Please explain: _____
_____

Family History:
This child is :
_____ my biological child
_____ adopted
_____ a foster child
_____ within legal guardianship
Who else lives in the home with this child? (please list names and ages) _____
_____
_____
Describe any speech, hearing, or learning problems of any relatives: _____
_____
List any allergies of family members:

Behavior:
Please check the following that apply to your child. Use the space below to give examples:
_____ withdrawn; shy
_____ poor eye contact
_____ poor attention span
_____ overly active
_____ temper tantrums to get his/her way
_____ physically aggressive when upset

How do you discipline this child? _____
_____
_____
_____

Have you ever considered that your child may have autism? _____
Why?_____
_____

Please provide any other comments that you would like for us to know about your child before his evaluation appointment.