CASE HISTORY INFORMATION

Date of Evaluation:_________ Who accompanied the patient today?:________________

PATIENT'S NAME: First___________MI__Last______________ DOB:_______
Is patient Male or Female (Circle One)
PARENT/S:_________________________________
ADDRESS:__________________________ PHONE #: home___________________
__________________________ PHONE#: cell_____________________
PHONE#: work_____________________
PHYSICIAN:_______________________ REFERRED BY:__________________

INSURANCE INFORMATION:

Insured's Name:___________________________ Insured SS#_____________________
Insured's Employer:___________________________ DOB:________________________
Insured's Work Phone #_____________________________

FAMILY HISTORY:

Any family members with problems with: (circle) speech, hearing, learning, ADHD, Mental Retardation, other__________ Language(s) spoken in the home:______________

PRENATAL & BIRTH HISTORY:

Were drugs/alcohol used during pregnancy? Yes/no______________________________
Problems during pregnancy?:________________________Full term? yes/no Weight____
Was Pitocin used? Yes/no Induce OR speed up delivery? (Circle which reason)
Conditions during delivery or immediately following birth:____

DEVELOPMENTAL MILESTONES:

Motor Skills- (crawl/sit/walk) (Check one) _______ Normal _______ Delayed
Verbal Skills: babbled at ___months; first words at ___months; phrases at ___ months
Oral / Feeding Skills:

Breastfed: yes or no For how long: ___________________ currently? Yes / No
Bottle-fed: yes or no For how long: ___________________ currently? Yes / No
Sipper Cup: yes or no For how long: ____________________currently? Yes / No
Feeding Difficulties: yes or no For how long: ______________________________
Reflux: yes or no Treatment:_____________________For how long?__________
Liquid/solids coming up through the nose during feeding? Yes/no _______________
Suck pacifier OR fingers (Circle which one): yes or no How long:_______________
Picky-eater: yes or no____
Overstuff mouth: yes or no Drooling: yes or no Gagging when eating? yes or no
Chews on objects?: yes or no Be specific: __________________________________
Type of Toothbrush: regular or electric Having Teeth brushed: likes or resists
Excessive Mouth-breathing?: yes or no Grinds teeth? yes or no

(More information on back)

HISTORY OF ILLNESSES: (Please Circle)

Allergies Frequent Colds Upper Respiratory Infections Asthma
High Fevers Tonsillitis Pneumonia Congestion (chest or nasal) Seizures
Head Injury Genetic Disorder Surgery Noisy Breathing Snoring Sleep Apnea

HEARING:

Suspect a hearing problem?: yes or no
Pass Newborn Hearing Screening?: yes or no
Hearing Tested: yes or no When____________ Where__________________________
Results____
Ear Infections: yes or no From: ____________ Until:____________ # per year ________
Tubes: How Many Sets of Tubes: ______When__________Doctor_________________
Hearing Aid: yes or no one or two Date of Amplification _____________________

PLAY SKILLS:

(Circle One) Independent or Interactive Play Skills: Appropriate or Inappropriate
Prefers playing with older or younger children

ADDITIONAL INFORMATION: (check all that apply)

___ Poor eye contact ___ Rarely plays with age appropriate toys
___ Resists touch/cuddling ___ Oversensitive to touch, noises, smells, etc.
___ Unusual sleep patterns ___ Difficulty with change in routines
___ Lines up toys & objects ___ Unusually high skills in academic areas (ABCs, #s, etc.)

PLACEMENT:

Daycare or Preschool from birth until five years old?: Yes or No
Where?____ # of days/wk___________
Current School:_____________________________________# of days/wk____________
Current Grade:________ Repeat any grades? Yes or No Which grade repeated? ______
Performance in Classroom:____
Has your child ***ever*** received speech therapy?: Yes or No When? __________________
Does Your Child receive services through the Special Educ. Dept.? Yes or No
Please explain____

OTHER CONDITIONS OR MEDICATIONS:

____

SENSORY ISSUES (to be filled out by therapist):

Auditory: ____
Visual: ____
Taste / Smell: ____
Vestibular / Movement: ____
Proprioceptive (Muscle & Joint): _______________________________________
Tactile / Touch: ____