LET'S TALK SPEECH & LANGUAGE THERAPY SERVICES, LLC

PEDIATRIC CASE HISTORY FORM

Child's Name:______________________________________Age:_________Date:_____________ _______

Date of Birth: _______________________________________Gender: ◯ Male ◯ Female

Address: ____Phone: _______________________________

City:___________________________________State:____________Zip Code:________________________

Completed by:___________________________________Relationship to Child:_______________________

Referred by:____Phone:___________________________

Family History

Parent's Name:____Phone:____________________________

Address (if different from above):____

Parent's Name:____Phone:___________________________

Address (if different from above)____

Siblings (include names and ages):

____

Child lives with:____

Language(s) child speaks:__________________________ Language(s) spoken at home:___________________

Is there family history of speech-language disorders:____

Medical Information

Child's current health status (circle one): ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Child's current weight:_______________height:_____________________________________ ____________

Date of most recent physical or doctor's visit:____ ____________

Current Physician's name: _________________ __________________Phone: ___________________________

Physician's address: ____ ______

Previous history of illnesses (list illness and age of occurrence):

____

____

802 Washington Street, South Easton, MA 02375 phone (508) 230-8181 fax (508) 230-8182
www.letstalkspeech-mass.com

Allergies:____

Surgeries/Accidents:____

1.___________________________Hospital/Doctor:_____________________________Mo/Year:___________

2.___________________________Hospital/Doctor:_____________________________Mo/Year:___________

3.___________________________Hospital/Doctor:_____________________________Mo/Year:___________

Medical Diagnosis:

1._________________________Facility/Professional:___________________________Mo/Year:___________

2._________________________Facility/Professional:___________________________Mo/Year:___________

3._________________________Facility/Professional:___________________________Mo/Year:___________

Medications:____

Hearing/Vision

Passed newborn hearing screening? ◯ yes ◯ no

Passed hearing screening/evaluation? ◯ yes ◯ no Date of last hearing screening/evaluation:___________

Location of last hearing screening or evaluation:____

History of ear infections/draining? ◯ yes ◯ no Please explain:___________________________________

Does your child wear glasses? ◯ yes ◯ no

Any hearing or vision concerns/issues?:____

Prenatal and Birth History

Mother's health during pregnancy:____

Length of labor:________________________Birth weight:____

Was child born premature ◯ yes ◯ no Gestational period (weeks):_______________________________

NICU? ◯ yes ◯ no Is yes, length of stay: ____

Delivery (check one) ◯ vaginal ◯ breech (feet first) ◯ C-section

Child's condition at birth: ◯ jaundice ◯ blue ◯ breathing ◯ other:____________________________

Any complications during pregnancy or birth:____

Developmental Milestones (Please list ages or answer yes/no):

Crawling:______Walking:________Gestures:__________Sounds:___________First words:_______________

Combining words:__________Speaking in sentences:____________Communicates wants/needs:____________

#of words used:_________# of words understood:__________Asks questions:________Answer questions:____

Understands commands:__________Conversation turns:____________Imitates face/speech sounds:__________

Play with others:_______________Understands function of objects (brush for hair):_______________________

Is your child difficult to understand?:______________By family or unfamiliar listeners?:__________________

Play interests:____

Education

School:__________________________________Grade:_____________Teacher:_______________________

Please describe: Academic progress (average/concerns):____

Social/interaction (average/concerns):____

Special education services? (IEP/504):___________ Dates of services: _________________________________

Types of services received and goals (list or attach documents):_______________________________________

____

Previous Therapy/Evaluations

Early Intervention Services? ◯ Current ◯ Past

Early Intervention Program:__________________________ Start Date (Month/Year):__________________

End Date (Month/Year):____________ Service Providers (Developmental Specialist, SLP, OT, PT, etc.):

____

____

Has your child previously received a speech-language evaluation? ◯ Yes ◯ No

Date of evaluation:______________________ Location of evaluation:________________________________

Has your child previously received speech-language therapy services? ◯ Yes ◯ No

Location:__________________ Start Date (Month/Year):_____________ End Date (Month/Year):__________

Location:__________________ Start Date (Month/Year):_____________ End Date (Month/Year):__________

Has your child received any of the following types of evaluations and/or therapy services (check all that apply):

___Occupational Therapy ___Physical Therapy ___Neurology ___Neuropsychology ___Psychology

Other:____

Please specify **dates and locations** of therapy services or evaluations:___________________________________

____

Sign:____**Date:**_____________________________