



FAULKNER UNIVERSITY

CENTER FOR THERAPY AND RESEARCH

Speech Language Pathology Pediatric Case History

Please complete the form to the best of your ability and return it prior to your evaluation appointment. We will review this form with you and help you complete it during our visit with your child.

(Please include copies of related evaluations and/or current IEP's)

Today's Date _____

Child's Name _____ Sex _____

Age _____

Birth date _____

Mother's (or guardian's) Name _____

Phone# _____

Father's (or guardian's) Name _____

Phone# _____

Home Address _____

Who has custody of this child? _____

Who is filling out this questionnaire? Relationship to child _____

EXPLANATION OF CONCERNS

Describe your concerns regarding your child's speech, language, hearing or feeding/swallowing: _____

When did you first notice the issue(s)? _____

Do you feel that your child's speech and/or language is different than children his or her own age? (Circle One) Yes No

Describe: _____

Who have you seen regarding these issues? (i.e., Doctor's, Psychologist, etc., Include name, address and telephone number) _____

Has your child ever received a speech language evaluation? (Circle One) Yes No

By whom? _____

When? _____

How has this issue changed since you first noticed it? _____

What has been tried to help with the issue? _____

What has helped/not helped the issue? _____

How does the issue affect your child or family? _____

FAMILY INFORMATION

Language(s) spoken in the home _____

Father's occupation _____ Employer _____

Mother's occupation _____ Employer _____

Level of Education:

Father _____

Mother _____

Siblings: Names & Ages:

Are there any family members or relatives who have or had received any kind of Special Education Services? (Circle One) Yes No

Describe: _____

Are there any family members or relatives who have or had any speech, language, Hearing or feeding/swallowing issues? (Circle One) Yes No

Describe: _____

MEDICAL HISTORY

Is this your biological child? Yes No

If not, can you provide information about the child's biological parents? _____

During pregnancy with this child, did the mother have any illnesses? Yes No

If so, what? _____

During pregnancy with this child, did the mother take any medications? Yes No

If so, list: _____

During pregnancy with this child, did the mother use drugs or alcohol?

Yes No

If so, list: _____

Was labor at all problematic?

Yes No

If so, explain: _____

Was the child's birth at all problematic?

Yes No

If so, explain: _____

Type of Delivery: (Circle One)

Vaginal Cesarean

Did your child have any trouble breathing after birth?

Yes No

Was the child kept in an incubator?

Yes No

If so, explain _____

Was feeding a problem?

Yes No

If so explain: _____

Were there any other problems after birth?

Yes No

If so, explain: _____

Has your child ever been hospitalized?

Yes No

Age and reason: _____

Has your child ever had any serious illnesses or accidents?

Yes No

Explain: _____

Has your child ever fainted?

Yes No

If so, explain: _____

Has your child ever had seizures?

Yes No

Describe: _____

Does your child have problems hearing?

Yes No

Has your child had ear Infections?

Yes No

If so, how many? _____

Last hearing exam date and results: _____

Has your child had middle ear tubes inserted? Yes No

If so, when? _____

Did your child have his/her tonsils/adenoids removed? Yes No

If so, when?: _____

Does your child have any problems seeing? Yes No

Wear glasses? Yes No

Does your child have any trouble sleeping at night? Yes No

Waking up in the morning? Yes No

Explain: _____

Does your child have allergies or asthma? Yes No

If so, list: _____

List all medications your child takes:

Pediatrician's name, address, and telephone number: _____

Please list other professionals your child sees:

ENT _____

Psychologist _____

Therapist _____

Neurologist _____

Physical Therapist _____

Occupational Therapist _____

Other specialists _____

Describe any other medical history: _____

DEVELOPMENTAL HISTORY

Feeding Development

Bottle fed? Yes No

Breast fed? Yes No

Age weaned from bottle? _____

Age weaned from breast? _____

Skill _____ Age _____

Drink from an open cup _____

Drink from a straw _____

Eat with fingers _____

Eat with spoon _____

Eat with fork _____

Does your child have any feeding or swallowing problems now? Yes No

Describe: _____

Is he/she a picky eater? Yes No

If yes, please explain _____

List some foods your child eats in each category:

Pureed foods _____

Dry crunchy foods _____

Wet chewy foods _____

Gummy/sticky foods _____

Physical Development

Skill _____ Age _____

Sit alone _____

Crawl _____

Pull up _____

Stand _____

Walk _____

Run _____

Jump _____

Dress self _____

Throw a ball _____

Toilet trained _____

Does your child wet the bed? Yes No

How often? _____

If your child has difficulties with any of the above or any other motor activities, please explain: _____

Describe any concerns you have with your child's physical development: _____

SPEECH/LANGUAGE HISTORY

<u>Skill</u>	<u>Age</u>
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Coo	_____
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Babble	_____
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First word	_____
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Combine 2 words	_____
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Sentences	_____
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Describe how your baby communicated as an infant: _____

List first words: _____

Approximately how many words did your child have at

12 months: _____

18 months: _____

24 months: _____

Describe how your child communicates now: _____

How well can you understand your child's speech? _____

How well do others understand your child's speech? _____

Describe what your child does if you do not understand what he/she is trying to communicate: _____

Do you think your child stutters or stammers? Yes No

Describe: _____

How does your child respond when you ask him/her a question? _____

How does your child respond when you give him/her directions to follow? _____

Reading and Writing (if age appropriate please complete)

Describe any problems your child has had with

Reading: _____

Writing: _____

How often do you read to your child? _____

List some of your child's favorite books: _____

Math

Describe any problems your child has had with learning math: _____

Cognitive Development

Which toys did your child play with at:

1 year _____

2 years _____

3 years _____

4 years _____

5 years _____

Current age _____

Does your child seem to learn quickly? Slowly? Average?

How would you describe your child's learning style? _____

How does your child solve everyday problems? _____

Provide an example if possible: _____

How does your child show reasoning skills? _____

How does your child do when trying to follow multi-step directions? _____

EDUCATIONAL HISTORY

Where does your child attend school? _____

What grade does your child attend? _____

List any concerns you noticed your child having at school: _____

List any concerns the child's teacher has expressed: _____

What has the school tried to address these concerns? _____

How does your child make and interact with friends? _____

What are your child's strengths? _____

What does your child enjoy? _____

Provide any other information you would like for us to know _____
