**NEW PATIENT PAPERWORK: CHILD CASE HISTORY**

**GENERAL INFORMATION:**

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| Child’s Name (Last, First, MI): | | Birthdate (MM/DD/YYYY): |
| Home Address: | | City / State / Zip: |
| Email Address: | | |
| Mailing Address (If Different): | | |
| Phone (Preferred):  Home  Cell | Phone (Alternate):  Home  Cell | |
| Child’s physician: | Child’s school: | |
| Who referred you: | | |

**PARENT INFORMATION:**

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| --- | --- |
| Father’s Name | Occupation: |
| Relationship to child:  Natural parent  Adoptive parent  Step-parent  Foster parent  Other: | |
| Mother’s Name | |
| Relationship to child:  Natural parent  Adoptive parent  Step-parent  Foster parent  Other: | |

**FAMILY HISTORY:** List close relatives (parents, aunts, uncles, grandparents, siblings) of the child who have had the following.

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| Speech and/or language disorders: |
| Hearing loss: |
| Intellectual disability (general learning disability, mental retardation): |
| Epilepsy / Seizures: |
| Known medical syndromes or problems: |
| Known birth defects; |
| Cleft palate / cleft lip: |
| Emotional / nervous problems: |
| Allergies: |
| Learning disabilities: |
| Other: |

Please list the name, age, and sex of the child’s brothers and sisters. Please indicate those children who are half-brothers/half-sisters or step-brothers/step-sisters as well as any other children who are living in the household.

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| Name: | Age: | Sex: | Relationship | General Health: |
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**PREGNANCY:** Please answer the questions below that are applicable to the pregnancy with this child.

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| Illnesses during the pregnancy: |
| Medications taken during the pregnancy: |
| Emotional or physical problems: |
| Any other difficulties during this pregnancy: |

**BIRTH & EARLY INFANCY:**

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| Normal birth  Breach birth  Caesarian birth  Forceps delivery | |
| Birth defects / known diagnosis: | |
| RH Incompatibility: | Blood transfusion: |
| Birth weight: | Duration of labor: |
| As a baby, the patient was:  Very good  Good  Average  Difficult | |
| Additional comments: | |
| Indicate all applicable:  Infant seizures / convulsions  Bottle fed  Breast fed  Incubator / isolette  Days oxygen administered:  Anoxia (blue coloring)  Infection  Jaundice  Suckling or swallowing problems (explain below): | |
| How long did the baby stay in the hospital? | |
| Did the baby require any special diet? | |
| At what age did the baby stop breastfeeding? | At what age did the baby stop bottle feeding? |
| Has this child experienced ear infections? | If so, at what age(s)? |
| Methods of treatment used (e.g. antibiotics, tubes, etc): | Has a hearing assessment been performed? If so, by whom? |
| Date of hearing assessment: | Results of hearing assessment: |

**CHILD DEVELOPMENT-PRESCHOOL YEARS: Provide the age at which your child first began doing the following.**

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| Sit alone: | Crawl: | Walk alone: |
| Eat with a spoon: | Hold a cup and drink alone: | Say first word: |
| Get first tooth: | Become toilet trained: | Dress him/herself: |
| What is your child’s hand preference?  Right  Left  Neither | | |
| Is/was your child overactive? | | |
| At what age was any balance problems noted: | | |
| Is/was your child easily distracted? | | |
| How would you describe your child prior to age 5?  Very good  Good  Average  Difficult  Very difficult | | |
| Additional comments: | | |

**CURRENT PATTERNS & FUNCTIONING:**

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| --- | --- | --- | --- |
| Describe in your own words your child’s speech-language problem. | | | |
| When and by whom was the problem first noticed? | | | |
| What do you think caused, or is causing, the problem? | | | |
| Does your child seem to be aware of the problem? | | | |
| If so, how does he/she react to speaking with family members? | | | |
| With other children? | | | |
| With strangers? | | | |
| Does he/she have more, less, or the same amount of difficulty at school, home, or new places? | | | |
| What efforts have been made to improve your child’s speech? | | | |
| Has your child had any previous speech-language therapy?  Yes  No | When: | Where? | How long? |
| Is your child more active than average for his/her age? If so, please describe. | | | |
| What ages are your child’s playmates: | | | |
| What toys does your child prefer? | | | |
| Is your child’s current disposition best described as:  Very easy going  Good natured  Average  Difficult  Very difficult | | | |
| Additional comments: | | | |
| Has your child has surgery? If so, list type(s) and dates: | | | |
| Has your child had any high fever? If so, please state how high, duration, and at what age. | | | |
| Cause of fever, if known: | | | |