GREAT BASIN SPEECH THERAPY

COMPREHENSIVE IN-HOME SPEECH & LANGUAGE THERAPY

Pediatric Case History

Please fill out this form as completely as possible. This history form provides necessary background information so your therapist can prepare the most appropriate evaluation.

Today's Date: _____ Age: _____ Grade_____ Sex: M F
Child's Name: _____ Parent(s): _____
Date of Birth: _____

FAMILY HISTORY

Is there a history of developmental delays in any area (e.g., speech, motor skills)? *Please indicate the family member and the diagnosis:

_____
_____

Where does the child currently live? Who lives in the home? Please list the ages of other children in the home.

_____
_____

Is a social worker or case manager involved in this child's care? Yes_____ No_____
(If yes, please list names and contact information):

_____

PREGNANCY AND BIRTH HISTORY

Did the mother receive prenatal care? Yes_____ No_____ (If no, please explain):

_____
_____

Were there any pregnancy complications (e.g. Pre-eclampsia, Gestational Diabetes, Bed Rest)?
Yes_____ No_____ (If yes, please explain):

_____
_____

Was the child delivered full-term? Yes_____ No_____ (If no, at what week) _____
Was the birth vaginal or C-Section_____
Were there any complications at birth (e.g., lack of oxygen, low APGAR scores)? Yes____ No____
(If yes, please explain):

DEVELOPMENTAL HISTORY

Please indicate at what age your child achieved the following skills (approximate age):

Crawled:
Walked:
First Words:

Are there any sensory issues/difficulties that you are aware of (please describe):

_____
_____

MEDICAL HISTORY

Please list any serious illnesses/accidents/hospitalizations (past or present_____
_____
Are there any medical diagnoses?
_____
_____
Does the child have a history of ear infections? If yes, how were they treated (meds, tubes, etc.)?
Has the child's hearing been evaluated? If so, what were the results? _____
_____
_____
Has your child's vision been evaluated? When and by whom? What were the results?
_____
_____
Any allergies to food, or environmental items we should know about? Yes_____ No_____ (If yes, please list the items): _____

Additional History

Has your child received any therapy services in the past (List dates and type of therapy)?
_____
_____
Does your child interact appropriately with children the same age? Yes_____ No_____
_____
_____
Does your child have any behavioral issues that are a problem? Yes_____ No_____
_____
_____
Describe items your child finds reinforcing (food, stickers, TV characters, etc.) _____
_____
_____
Why are you seeking therapy currently (i.e., main concerns)? What are your goals?
_____
_____
_____

NOTES OR ADDITIONAL INFORMATION:

Thank you for taking the time to complete this form. This information will be very helpful to your therapist in helping to create a therapy program specific to your child's needs.