Pediatric Case History

Personal Information

The information provided on this form is confidential. It is used to appropriately prepare for the evaluation.	
Date:	**Person completing form:**
Relationship to child:	
Personal Information	
Child's Name (First and last names):	
Date of Birth:	**Nickname:**
Age:	
Sex:	
What are your and/or other's concerns about your child's speech-language/ communication/ learning and /or feeding skills:	
What is/are your goal(s) for your child in receiving Speech-Language Therapy services:	
Referred by:	
Medical Healthcare Provider	
Name (Physician name NOT clinic name)	
Clinic	Phone
Communication	
How does your child communicate? □ Talking □ Gestures □Grunts/Sounds □ Sign-language □ Picture Communication System □ AAC device □ Non-verbal/Non-communicative	
What language or languages does your child speak?	**What language or languages are spoken in the home?**
Areas to be evaluated:	
Understanding/Receptive Language: □ Understands what is said to them, can follow directions, answers questions, etc. that is similar to peers/siblings □ Appears to have difficulty understanding what is said to them. Appears to be lower than peers/ siblings Describe what you notice	
Expressive Language □ Uses words and /or sentences that is appropriate for age, similar to peers/siblings □ Uses words and/or sentences that appear to be lower than peers/siblings Describe what you notice	

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Speech Sounds/Articulation
□ All sounds are produce and are similar to peers/siblings
□ Speech sounds are in error
Which sounds? _____
Check all that apply:
□ Substitutes sounds (tat for cat)
□ Distorts sounds (lisp)
□ Leaves out sounds (ba for bat or do for dog)

Approximately how much do you understand your child's speech?
□ Less than 10% □ 25% □ 50% □ 75% □ 90-100%

Approximately how much do others less familiar with you child understand your child's speech?
□ Less than 10% □ 25% □ 50% □ 75% □ 90-100%

Areas to be Evaluated

Oral/Mouth
□ No past of present oral habits or behaviors
□ Yes, there are past and/or present oral habits and/or behaviors

Please check all the apply if answered Yes:
□ Drooling
□ Mouth breather (open mouth when not talking)
□ Sucks
□ Chews
□ Snores

If child sucks please describe:	**If child chews please describe:**
Does the child continue to suck?	**Does the child continue to chew?**
At what age did the child stop?	**At what age did the child stop?**

Orthodontic Work:
□ Currently receiving Why? _____
_____
□ Recommended for the future Why? _____
_____
□ Has not been recommended and/or not appropriate at this time

Thinking/Executive Function Skills
□ No concerns with organizational skills, problem solving, memory, thinking, reasoning, etc.
□ Has problems with organizational skills, problem solving, memory, thinking, reasoning, etc.
Please describe

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Social Communication Skills
□ No concerns with conversation/verbal interaction skills with peers and/or adults
□ Concerns with conversation/verbal interaction skills with peers and/or adults
Please describe

Social Interaction/Play
□ No concerns with playing with peers, siblings, and/or adults
□ Concerns with playing with peers, siblings, and/or adults
Please describe

Stuttering/Fluency
□ No concerns with stuttering
□ Concerns with stuttering (past or present)
Please describe

Voice (how their voice sounds not the sounds of speech)
□ No concerns about voice
□ Concerns about voice
Please describe

Feeding/Eating/Swallowing
□ No past or present concerns about feeding, eating, and/or swallowing solid foods including textures (crunchy, soft, etc.), consistencies (puree, soft, regular), temperature, and/or liquids
□ Concerns (past of present) about feeding, eating, and/or swallowing solid foods including textures (crunchy, soft, etc.), consistencies (puree, soft, regular), temperature, and/or liquids
Please describe

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Special Diet Considerations?
□ Yes □ No
Please describe

Does the child have any food allergies/sensitivities?
□ Yes □ No
Please list

Behavior
□ No behavioral concerns □ Concerns about behavior
Please describe

Sensory
□ No sensory concerns □ Concerns about sensory
Please describe

Personal Information

Please list all persons the child lives with and relationship to the child

Please provide any important information (divorced or separated parents, significant family events, legal matters (example custody, parental rights, etc.) Please not if there are legal issues such as custody, guardianship, etc. we require a copy of the court papers for HIPPA compliance purposes.

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Social/Extra-curricular activities (ex: play groups, church, scouts, clubs, etc.)
□ Does not participate in and social/extra-curricular activities
□ Participates in the following social/extra-curricular activities
List social/Extra-curricular activities

Favorite/Preferred games, toys, activities, books, etc. (list):

Family (parents, siblings, grandparents) history of speech-language, communication, learning, and/or developmental impairments
□ No family history of speech-language, communication, learning, and/or developmental impairments
□ Yes family history of speech-language, communication, learning, and/or developmental impairments
List relationship to child and the impairment, e.g. Dad speech)

Education:

Current educational setting (day care, preschool, home schooling, online school, public/private school etc.)
□ Does not attend an educational setting
□ Attends at the following educational setting
Please give the name of the setting, type of setting including school district and grade (if applicable)

Learning/Academic
□ No past or present learning or academic concerns
□ Have past and/or present learning/academic concerns
Please describe

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Current IEP/FSP (Early Intervention) or 504 Plan
□ Does NOT have and IEP/FSP or 504 Plan
□ Has an IEP/FSP
□ Has 504 Plan
□ Did not qualify for and IEP/FSP or 504 Plan although there are concerns
□ Currently undergoing testing for an IEP and/or 504 Plan
□ No longer on an IEP/FSP or 504 Plan for _____

Has an IEP/FSP for the following service (check all that apply)
□ Preschool Education/Child Find
□ Educational: _____
□ Speech-Language Therapy
□ Occupational Therapy
□ Physical Therapy
□ Behavior
□ Autism
□ Mental Health
□ Audiology
□ Medical

No longer on an IEP/FSP for the following service (check all that apply)
□ Preschool Education/Child Find
□ Educational: _____
□ Speech-Language Therapy
□ Occupational Therapy
□ Physical Therapy
□ Behavior
□ Autism
□ Mental Health
□ Audiology
□ Medical

Early Intervention
□ Currently receives Early Intervention services in the home
□ Aged out (turned 3) and will continue to receive IEP services in preschool
□ Age out (turned 3) and no longer qualifies for services
□ Did no receive Early Intervention Services

Evaluations/Therapies and/or Services outside of school

Speech-Language Therapy
□ Currently
□ Previously
□ Neither

If Currently/Previously, where?	**Date last seen:**

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Occupational Therapy □ Currently □ Previously □ Neither		
If Currently/Previously, where?	**Date last seen:**	
Physical Therapy □ Currently □ Previously □ Neither		
If Currently/Previously, where?	**Date last seen:**	
ABA/Behavioral Therapy □ Currently □ Previously □ Neither		
If Currently/Previously, where?	**Date last seen:**	
Developmental Evaluation/Autism Evaluation □ Yes □ No		
If Yes, When?	**Where?**	**Diagnosis?**
Counseling/Mental Health □ Currently □ Previously □ Neither		
If Currently/Previously, where?	**Date last seen:**	
Tutoring/Academic Support □ Currently □ Previously □ Neither		
If Currently/Previously, where?	**Date last seen:**	

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Horse/Hippo Therapy □ Currently □ Previously □ Neither	
If Currently/Previously, where?	**Date last seen:**
Vision Therapy □ Currently □ Previously □ Neither	
If Currently/Previously, where?	**Date last seen:**
Hearing Therapy □ Currently □ Previously □ Neither	
If Currently/Previously, where?	**Date last seen:**
Other therapies and/or services □ No other therapies and/or services □ Has other therapies and/or service	
Other therapies and/or services information	

Health/Medical Information

Please select one of the following: □ There are no known past or present Medical concerns □ Known medical conditions/illness/injuris past or present:		
Attention Deficit Disorder □ Yes □ No	**Age**	**Medication** □ Yes □ No
Asthma □ Yes □ No	**Age**	**Medication** □ Yes □ No
Autism □ Yes □ No	**Age**	**Medication** □ Yes □ No

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Brain Injury □ Yes □ No	**Age**	**Medication** □ Yes □ No
Global Developmental Delay □ Yes □ No	**Age**	**Medication** □ Yes □ No
Chronic upper respiratory infections □ Yes □ No	**Age**	**Medication** □ Yes □ No
Ear Infections □ Yes □ No	**Age**	**Tubes** □ Yes □ No
Tonsillectomy □ Yes □ No	**Age**	**Surgery Date**
Adenoidectomy □ Yes □ No	**Age**	**Surgery Date**
Tongue Tie □ Yes □ No	**Age**	**Surgery Date**
Seizures □ Yes □ No	**Age**	**Medication** □ Yes □ No
Syndromes and Other Diagnoses □ Yes_____ □ No	**Age**	**Medication** □ Yes □ No
Psychological/Mental Health □ Yes □ No	**Age**	**Medication** □ Yes □ No
Cranio-facial (cleft lip/palate) □ Yes □ No	**Age**	**Surgery Date**
Other medical diagnoses pertinent to speech □ Yes □ No		
If other, please specify		

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Please add any further details to the information above that you feel is helpful		
Allergies and/or sensitivities □ No known allergies and/or sensitivities □ Yes, known allergies and/or sensitivities other than foods		
If allergies, please specify		
Requires an EPI pen? □ Yes □ No		
Vision		
Vision Impairment □ Yes □ No		
Wears glass and/or contacts □ Yes □ No	**Please specify**	
Vision tested/screened □ Yes □ No	**Date of test** **Where?**	**Pass/Fail screening** □ Pass □ Fail
Hearing		
Hearing Impairment □ Yes □ No		
Wears and amplification system or filter □ Yes □ No	**Please specify**	
Vision tested/screened □ Yes □ No	**Date of test** **Where?**	**Pass/Fail screening** □ Pass □ Fail
Sleep		
Sleep □ Sleeps through the night without waking, except toileting □ Wakes frequently during the night. Reason: _____ □ Has difficulty falling asleep		

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Developmental Milestones

Speech

□ Babbled, began using words, formulating sentences and asking questions that was typical of peers

□ Babbled and talking earlier than peers or same as peers and stopped. Age stopped: _____

□ Did not babble or start talking after age 18 months

□ Imitates only/Echolalic (repeats what has heard and not vocalizing spontaneous utterances)

□ Is not talking, babbling, or verbalizing/vocalizing

Motor

□ Reached motor milestones (crawling, walking, sitting, rolling over, etc.) on time

□ Was significantly delayed in reaching developmental milestones and/or body coordination

Please describe

Prenatal/Pregnancy/Birth and Neonatal Information

Overall health of mother during pregnancy was:

Length of Pregnancy (number of weeks):

There were NO problems or concerns during

□ Pregnancy

□ Delivery

□ Birth

□ 1-3 days after birth

The following were present during pregnancy and/or birth. Please check all that apply

□ Substance Abuse: Illegal drugs, alcohol, prescription medication

Please describe:

□ Medical Concerns

□ Pregnancy/Prenatal (e.g. Toxemia, Rh Incompatibility, etc.)

□ Birth Delivery (e.g. Bleeding, breach, required oxygen, cord around neck, injury, etc.)

Please provide details to the medical concerns/conditions that were present:

Neonatal concerns that required Special Care Nursery (SCN) or Neonatal ICU (NICU):

□ Yes Why?_____ □ No	**Length of time:**	**What services received?**

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Other concerns/information. Please use this box to share any further information that we did not touch on that would help us to know your child

Acknowledgement

I have provided accurate information to the best of my knowledge and understand that this document will be uploaded into my child's Lots of Language medical record and can be accessed by third party agencies including but not limited to: primary care and specialty care healthcare providers, insurance carrier, educational institutions, and other service providers with signed release of information. I understand that any documents that I provide, electronically or paper, will be uploaded into my child's Lots of Language medical record for the sole purpose of providing my child with an accurate diagnosis pertaining to communication and to provide effective and adequate treatment. These documents cannot be shared with a third party even with a release of information as they were not generated by Lots of Language. I can request the document(s) be sent to a third party in writing.
Signature:
Relationship to child: