Pediatric Case History

Date_____

Patient's name_____ Name patient is called_____

Date of Birth_____ Parent's Name_____

Person completing forms:_____ Relationship to child_____

Reason for visit today: ____Speech Therapy _____Occupational Therapy ____Physical Therapy

Why was your child referred for an evaluation?_____

What would you like your child to achieve in therapy? What is your goal for your child?_____

_____

Who is the primary care physician?_____ Phone number_____

Names and telephone numbers of other physicians who treat your child_____

_____

If your child has received therapy in the past, please list the location and dates of therapy:

Speech Therapy _____

Occupational Therapy _____

Physical Therapy_____

Does your child receive psychological services, counseling, ABA therapy or play therapy?

____yes ____no Where?_____

Name and phone number of therapists, psychologist or counselor_____

Previous surgeries and dates _____

Does your child attend day care, preschool or school? ___yes ___no If yes, please list the location.

_____ Grade_____

Does your child have an Individualized Education Plan (IEP) or an Individualized Family Service Plan (IFSP)? ____yes ____no **Please provide us with a copy of these documents.**

Family History: Name Age Occupation

Father _____

Mother_____

Siblings_____

_____

Who does the child live with? _____

Pregnancy History:

Was pregnancy full term? _____yes _____no Number of weeks _____

Were there any pregnancy or birth complications? _____yes ____no Please List_____

_____

Childs birth weight_____ Age of mother at birth_____ Age of Father at birth_____

Was child breast fed or bottle fed? _____

Were there any feeding difficulties at birth? _____

Developmental History: Please list any developmental skills that were delayed._____

_____

Please list the age these skills first occurred: _____smiling _____laughing _____eye contact

babbling _____ first words_____ 2 word combinations_____ speaking in sentences_____

sitting up_____ Crawling_____ walking_____ finger feeding_____ rolling_____

spoon feeding self_____ drinking from cup_____ _ following directions_____

potty trained_____

Do you have any concerns about your child's development? Please explain_____

What percent of your child's speech would a stranger understand? _____%

What percent of your child's speech do you understand? _____%

Please describe the speech problem_____

_____

Is your child overly sensitive to certain things? (touch, sound,taste)_____

_____

Is your child independent with self help skills? (dressing, bathing, eating)_____

_____

Does your child give appropriate eye contact when interacting with others? ____yes ___no

Does your child play well with other children? ____yes ____no

What activities does your child enjoy?_____

What toys does your child enjoy?_____

Does your child play with toys the way they were meant to be played with? ____yes _____no

If no, please explain_____

Does your child have any behaviors you are concerned about? ____yes ____no Please explain:

_____

_____

Medical History: Check any of the following that apply for your child

__hospitalizations __vision problems __hearing problems __difficulty sleeping

__ear infections How many?___ __seizures __chronic illness Please list_____

__lung/bronchial problems ___ heart defect __head injury ___feeding tube

__other medical issues Please list_____

Has your child had a hearing evaluation? ___yes ___no If yes, please list location and dates.

_____

Please list all medications your child is currently taking and what the medication is for.

_____

Feeding History:

Does your child have any feeding or swallowing issues? _____ yes ____no Please explain:

_____

Has your child ever had aspiration pneumonia? ____ Yes ____ No When? _____

What types of foods does your child prefer?_____

Are there any foods your child chokes or gags on? ____yes ___no Please explain: _____

_____

Does your child have any feeding issues or have diet modifications? ____yes ___no Please explain:

_____

What does your child drink from? _____bottle ____sippie cup ____straw cup ____open cup

Has your child had a Modified Barium Swallow (X-ray swallow test)? ___yes ___no Dates_____

Are there any other feeding or swallowing concerns?_____

_____

What types of foods, activities, rewards does your child really enjoy? _____

_____

We may use foods, candy, stickers and play activities in therapy . Are there any of these that you do not want your child to have during therapy? _____

Please list any other information that you feel is important in evaluating your child's communication and feeding/swallowing development:_____

_____

_____

_____