

**Lucile Packard Children's Hospital
Rehabilitation Services Department
Speech-Language Pathology Services**

Case History Form

IDENTIFICATION

Child's Name _____

Birth Date _____

Address _____

City, State, Zip code _____

Name of Parent(s)/Guardian _____

Contact Information (please include area code)

Home Number _____

Work Number _____

Cell Number _____

BACKGROUND INFORMATION

Describe your impression of your child's speech and/or language difficulties:

Is this child adopted? Yes No (Circle one)

If yes, when? _____

Other children in the family:

Name	Age	School Status	Relationship to child being seen by us

Who is the daytime caregiver(s) for the child (please circle all that apply)

Parent

Nanny

Daycare program

Family member

Babysitter

Other (please specify)

Has anyone in the family had:

	Yes	No	If so, please describe
Speech problems			
Language Problems			
Delayed onset of speech and language			
Learning problems			
Behavioral problems			
Seizures			
Chronic illness of any kind			

Has your child ever had special help from:

	Yes	No	If yes, please describe.
Psychologist			
Speech-Language Pathologist			
Audiologist			
Special Educator			
Medical specialist (neurologist, orthopedist, ENT etc.)			

PREGNANCY, BIRTH AND DEVELOPMENTAL HISTORY

Pregnancy

During the pregnancy with this child was there:

	Yes	No	Do Not Know	If yes, please describe
Anemia				
Bleeding				
Blood Incompatibility				
Chemical substance use				
Diabetes				
Illness				
Injury				
Medication				
Smoking				
Toxemia				
X ray				
Anything considered unusual during pregnancy				

Delivery

Was this child born prematurely? Yes No (Circle one)

If yes, by how many weeks? _____

Delivery was: Normal Caesarean Breech (circle one)

Were there any complications during delivery? Yes No (circle one)

If yes, please describe _____

During the first month, was your child:

	Yes	No	If yes, for how long?
Cyanotic (blue)			
Jaundiced			
In an incubator			
Having difficulty with sucking or swallowing			
Other (please specify)			

Developmental Milestones

Give the age at which the following occurred:

Sitting alone _____

Crawling _____

Standing alone _____

Walking alone _____

Do you have any concerns about your child's ability to chew or swallow food or liquid?

Yes No (please circle one)

If yes, please describe _____

Have you noticed any unusual eating patterns for your child?

During Infancy? Yes No (please circle one)

Currently? Yes No (please circle one)

If yes, please describe (such as specific food preferences, chewing or swallowing problems) _____

Was there anything in your child's physical or mental growth that concerned you during his or her first 18 months of life? Yes No (please circle one)

If yes, please describe _____

Speech and Language Development

What was the child's first word?

How old was she/he? _____

Medical History

Is the child currently under medical treatment or on medication? Yes No (circle one)

Please list medications and the reasons for them _____

Does your child currently have (or did your child previously have) any of the following:

Condition	Yes	No	Age	Describe
Visual defect				
Glasses				
Cleft palate				
Hearing aid				
Ear infections				
Defect of tongue, jaw, teeth or lips				
Skull fracture				
Concussion				
Allergies				
Emotional or behavior problems				
Measles				
Chicken Pox				
Mumps				
Encephalitis				
Meningitis				
Pneumonia				
Impetigo				
Seizures				
Other (not listed above)				

CURRENT COMMUNICATION SKILLS

Please rate your child's current communication skills in the following four areas: (Circle the statement that best describes your child in each of the four areas.)

- 1. Understanding
 - a. Responds only to gestures
 - b. Responds to simple single verbal commands
 - c. Responds to complex verbal commands
 - d. Able to follow conversation in noisy environments

- 2. Expression
 - a. Communicates primarily by pointing and gestures
 - b. Communicates in single words or phrases
 - c. Converses in simple sentences
 - d. Converses at abstract or complex level

- 3. Speech
 - a. Understandable only to parents, family and familiar persons
 - b. Understandable to all people

- 4. Fluency
 - a. Normal
 - b. Repeats and/or prolongs individual sounds, words, or phrases
 - c. Trouble getting words out

EDUCATIONAL HISTORY

List the schools attended, including preschool programs:

Name of School	Location	Dates of attendance and grade level attained

Name of current school or program _____

Name of current school district _____

Current grade level: (circle one)

Preschool Kindergarten 1 2 3 4 5 6 7 8 High School

SUMMARY

Please list any other concerns not addressed above, including any that you would like specifically addressed during the evaluation.

Name of person completing this form _____

Relationship to child _____

Date completed _____

Thank you for taking the time to complete this form. It is an important part of the evaluation process and helps us to provide the appropriate evaluation for your child.

Last Updated 1/19/11