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Case History

Date completed : _____

Completed by: _____ Relationship to patient:_____

Patient's Name: _____Age: _____ Date: _____

Date of Birth:_____ Gender: ☐ Male ☐ Female

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Referred by: _____ Phone: _____

Reason for referral/concerns:_____

_____

Family History:

Father's Name:_____ Phone: _____

Address if different: _____

Mother's Name:_____ Phone: _____

Address if different: _____

Brothers and Sisters (include names and ages): _____

Language patient speaks? _____ Language spoken in home? _____

Is there any family history relevant to speech, language and feeding disorders?

_____

Medical Information:

Patient Current Health Status (please circle one): ☐Excellent ☐ Good ☐ Fair ☐ Poor

Current physician's name: _____Phone: _____

Physician's address: _____

Medical Diagnosis: _____

Has patient had any of the following? (Please check/circle ALL that apply and list age of occurrence if applicable):

☐ Rheumatic Fever ☐ Measles/Mumps ☐ Scarlet Fever ☐ Chicken Pox

☐ Pneumonia ☐ Headaches ☐ Asthma ☐ Mastoiditis

☐ Encephalitis ☐ Tonsillitis ☐ Allergies: _____

☐ Meningitis ☐ High Fevers ☐ Whooping Cough ☐ Croup

☐ High Fevers ☐ Seizures ☐ Respiratory Illness ☐ Tinnitus/Dizziness

Other (please list)_____

Surgeries/Major Accidents:_____

Medications: _____

Hearing/Vision:

History of ear infections/draining? ☐ Yes ☐ No Please explain:_____

Does patient wear glasses? ☐ Yes ☐ No

Any hearing or vision concerns/issues:_____

Date of most recent hearing evaluation: _____

Prenatal and Birth History:

Mother's health during pregnancy:_____

Was patient born premature? ☐ Yes ☐ No Gestational period (weeks): _____

Any complications during pregnancy or birth:_____

Feeding and Swallowing (if applicable):

Feeding Concerns: ☐ Difficulty Sucking ☐ Difficulty Chewing ☐ Nasal Regurgitation ☐ Drooling

☐ Watery Eyes ☐ Aspiration ☐ Cough ☐ Gag/Vomit ☐ Diet Restrictions ☐ Texture Avoidance

Any additional feeding, swallowing or dietary concerns/history, please explain: _____

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Developmental Milestones (Please list approximate ages):

Crawling:_____Walking:_____Gestures:_____Sounds:_____First Words:_____

Combine words?_____ Speak in sentences?_____ Communicate needs/wants? _____

# of words used: _____ # words understood:_____Ask questions?_____Answer questions?_____

Understand commands? _____ Conversation turns? _____ Imitate faces/speech sounds?_____

Play with others? _____ Understands functions of objects (brush for hair)? _____

Is patient difficult to understand? _____ By family or unfamiliar listeners?_____

Play interests/Additional Pertinent Information: _____

_____

Augmentative and Alternative Communication (if applicable):

Speech Generating Device (type): _____

Prior AAC evaluations and recommendations: _____

Education/Vocational:

School/Employer: _____ Vocational training? _____

Please describe: Academic/Vocational progress (adequate/concerns?): _____

Social/interaction (adequate/concerns?): _____

Has the patient had any prior Speech Therapy? Yes / No

If yes, please provide diagnosis and dates of service and attach any important documents (reports, goals, etc..)

_____

_____

Any other pertinent information that is important for the clinician to know? _____

_____

_____

Signed: _____ Date: _____