11635 Euclid Avenue · Cleveland, OH 44106 · 216-231-8787 · 216-231-7141 Fax
4257 Mayfield Road · South Euclid, OH 44121 · 216-382-4520 · 216-325-7609 Fax
7000 Town Centre Drive #200 · Broadview Heights, OH 44147 · 440-838-1477 · 216-325-7620 Fax

SPEECH-LANGUAGE PATHOLOGY PEDIATRIC CASE HISTORY FORM

Client Name: ____ **DOB:** ______________ **Sex:** ❑ Male ❑ Female

Statement of Problem:

Describe the concerns you have about the child's communication skills at this time:

What do you think may have caused the difficulties the child is experiencing?

When was the problem first noticed? Please specify a date if possible.

Are there any skills the child had learned previously, but no longer can use?

Have the child's communication abilities changed since this appointment was scheduled? ❑ Yes ❑ No
If yes, please explain:

I understand what the child says/communicates: ❑ *almost always* ❑ *usually* ❑ *infrequently* ❑ *almost never*

Others understand what the child says/communicates: ❑ *almost always* ❑ *usually* ❑ *infrequently* ❑ *almost never*

Has the child's hearing been tested? ❑ *Yes* ❑ *No* **If yes, please bring a copy of the hearing test results to your appt.**

If yes, where was the test completed? ____________________________________ Date Completed? ________________

Results of the hearing test: ❑ Hearing within normal limits ❑ Hearing loss ❑ Further testing required

Family Background:

Name(s) of Others Living with Child	Age	Sex	Relationship
		M F	
		M F	
		M F	
		M F	
		M F	

Please list the names of other people (not listed above) with whom the child spends a lot of time:

Is there a family history of speech, language, and/or reading difficulties? ❑ *Yes* ❑ *No*
If yes, note the person's relationship to the child (ex: father, sister, cousin, uncle) and what type of difficulties they had:

Medical History

Describe the mother's health during the pregnancy: ❑ *Good* ❑ *Fair* ❑ *Poor*

Comments:

Were there any unusual conditions that may have affected the pregnancy or birth?

Was the child full term? (38 weeks or more) ❑ *Yes* ❑ *No*: Length of the pregnancy ____________ Birth weight: ________

Type of delivery: ❑ *head first* ❑ *feet first* ❑ *breech position* ❑ *cesarean-section*

Please describe any difficulties during the delivery process:

Please describe any feeding problems the child experienced as an infant and/or any difficulty with swallowing or chewing as child got older:

Please continue on back

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Please check all items that apply and list age of occurrence:

Item	Age	Item	Age	Item	Age
❑ Allergies		❑ Encephalitis		❑ Pneumonia	
❑ Asthma		❑ High Fever		❑ Seizures	
❑ Chicken Pox		❑ High Lead Levels		❑ Sinusitis	
❑ Colds		❑ Injury to head, or fall		❑ Meningitis	
❑ Croup		❑ Measles		❑ Other (describe):	
❑ Ear Infections	How many?				

Please list any specialist(s) (ex: Speech, OT, PT, Early Intervention) the child has seen/currently seeing.
❑ N/A if no other specialists seen

Type of Service	Reason for Service	Date(s) Seen	Provider's Name

Please list the child's hospitalization/surgical history below: ❑ N/A

Hospitalization/ Surgery	Date(s)

Is there anything else we should know about the child's medical history?

Developmental History

Provide the approximate age at which the child acquired the following skills. If you can't remember the age, mark the box that best describes when he/she acquired the skill as compared to his/her peers.

Activity	Age	Earlier than Peers	Same Time as Peers	Later than Peers
Babbling (ex: "ba, ba")				
First words				
Put two words together/use short phrases				
Use complete sentences				
Sit				
Crawl				
Walk				
Feed Self				
Use toilet in daytime				
Use toilet at night				

How would you describe the child's motor development (running, skipping, grasping crayons) as compared to his/her peers?

The child is: ❑ Right Handed ❑ Left Handed ❑ No hand preference noted yet

Educational History

Years of School Completed: ___________________ Name of School: ____
How does the child interact with his/her peers?

Is the child learning as expected?

Describe the child's reading and writing skills: ❑ N/A

Does the child receive special services? (special education classes, reading, tutoring) ❑ Yes ❑No

Does the child have an IEP or IFSP? ❑Yes **Please bring a copy to your appointment.** ❑No

Person Completing this Form: ____

Relationship to Child: ____ Date Completed: ______________________