Pediatric Communication Case History Form

Please complete and bring to your first appointment or send to our office prior to your evaluation.

Patient's Name:

Patient's Date of Birth:

Name of person completing this form:

Relationship to the patient:

Date form completed:

Briefly describe your concerns for your child's speech and language:

What is the number one thing you hope to get from today's assessment?

Birth History

Were there complications during the pregnancy?	Yes	No	
If yes, please explain.			
Were there complications during the birth?	Yes	No	
If yes, please explain.			
Was the pregnancy full-term?	Yes	No	If no, how many weeks?
Was the child born with low birth weight?	Yes	No	
Were there any complications after the birth?	Yes	No	
If yes, please explain.			
Did your child pass the Newborn Hearing Screening?	Yes	No	

Medical History

Does child have any medical conditions?	Yes	No	
If yes, please explain.			
Has the child ever had ear infections?	Yes	No	
If yes, how many? How often?			
Did the ear infections respond to antibiotics?	Yes	No	
Has your child ever received ear tubes?	Yes	No	
Has the child ever had their hearing screened or tested?	Yes	No	
If yes, what were the results?			
Has the child ever had their vision tested at the pediatrician?	Yes	No	
If yes, what were the results?			

Does the child take any medications?	Yes	No	
If yes, please list:			
Does the child have any allergies?	Yes	No	
If yes, please list:			
Has your child had any surgery or medical procedures?	Yes	No	
If yes, please explain:			

Developmental History:

When did your child begin sitting unsupported?	On time	Delayed	Has not yet begun
When did your child begin crawling?	On time	Delayed	Has not yet begun
When did your child begin walking unaided?	On time	Delayed	Has not yet begun
When did your child speak their first words?	On time	Delayed	Has not yet begun
What languages are spoken in the home?			
Did your child have difficulty breast or bottle feeding as an infant?	Yes	No	
Does your child struggle now with eating or feeding?	Yes	No	
Has he ever had any other types of therapy?	Yes	No	
If yes, please list type, frequency, and duration.			
Is your child under sensitive or over sensitive to certain things like textures, actions or sounds?	Yes	No	
Where does the child spend most of the day?	Home	School	Daycare
What school do they attend?	Grade:		
Does your child have an IFSP (early intervention) or an IEP (at school)?	Yes	No	
Name of school/daycare:	Grade:		
Does the child have opportunity to play around other children?	Yes	No	What ages?
Does anyone else in the family have any delays or speech difficulty?	Yes	No	
Is the child aware of his/her communication difficulty?	Yes	No	
What are your child's interests?			
How would you describe your child?			

Is there anything else you can think of that you want to share?