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Case History Form

Date: _____

Child's Name: _____ Date of Birth: _____

Address: (*street*) _____

(*city/ state/zip*)_____

Mother: _____

Phone Number: _____ Email:_____

Father: _____

Phone Number: _____ Email: _____

Siblings: (*names and ages*) _____

_____

Name of School: _____ Grade: _____

Referred by: _____

Please provide us with a brief description of your concerns regarding your child:

_____

_____

_____

_____

Birth History

Was there anything unusual about the pregnancy or birth? ____YES ____NO

If yes, please describe:
_____
_____
_____

Mother's age at the time of birth: _____

Did your child go directly home from the hospital? ____YES _____NO

If your child stayed at the hospital, please describe why, any special care provided (ex: intubation, oxygen) and for how long:
_____
_____

Birth Weight: _____

Medical History

Pediatrician
Name: _____ Phone number: _____
Address: _____

Does your child have a medical diagnosis? ____YES ___NO
If yes, please list: _____

Other Physicians

Name	Specialty	Contact Information

Please list any medications your child is currently taking:
_____

Does your child have any allergies? ____YES ____NO
If yes, please list:_____

Date of last hearing screening or full audiological evaluation: _____
Results: _____

Does your child have PE tubes? ____YES ____NO
If yes, date inserted: _____

Does your child currently wear corrective lenses? ____YES ____NO
Date of last vision screening/evaluation: _____

Speech-Language History

At what age did your child display the following skills:

Skill	Age Displayed	Examples
Coo/babble		
Say first word/word approximation		
Name familiar objects		
Combine two words (i.e., "ball up")		
Ask simple questions (i.e., "Where cup?")		

Is your child's speech understood by you?
___YES ___SOMETIMES ___NO
Is your child understood by others who are very familiar with your child?
___YES ___SOMETIMES ___NO

Do you have concerns related to fluency or voice? ___YES ___NO
If yes, please describe: _____

What languages are spoken in your home? _____

Has your child previously received a speech-language evaluation? __YES __NO
If yes, where and when?_____
Results: _____

Has your child previously received speech-language therapy? ___YES ___NO
If yes, where and when?_____

Feeding Development
(Please complete this section only if you have concerns in this area)

Did you breastfeed your baby? ___YES ___NO
If yes, for how long? _____

At what age did your child:

- Drink from a straw - _____
- Drink from a cup- _____
- Eat table food - _____
- Use spoon/fork - _____

Please list your child's favorite foods:

_____
_____

Where do meals occur (high chair, booster seat): _____

Do you have a family mealtime? ___YES ___NO
If yes, how often? _____

Please describe any feeding challenges your child currently has (difficulties with sucking, swallowing, chewing, gagging, food preferences, etc):

_____
_____
_____
_____

Educational History

Please list your child's educational experiences:

	Name of Setting	Age/Date of Attendance	Languages Spoken within the Setting
Daycare			
Preschool			
Elementary School			
Middle School			
High School			
Other			

Is your child currently receiving any interventions at school? ____YES ____NO
If yes, please explain:

_____
_____
_____

What are your child's best subjects? _____
_____

What subject does your child find the most challenging? _____
_____

If you have any questions related to the completion of this form, do not hesitate to email me at anne@ARCCornerstones.com . We appreciate the time taken to complete this form in its entirety. The information gathered here will be useful in our evaluation of your child's communication (and feeding if indicated) challenges.