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GENERAL CASE HISTORY

REASON FOR EVALUATION:

____
____
____

Demographic Information:

Client's name: ___________________________
Client's date of birth: ____________________
Gender: _________________________________
Age: ___________________________________
Grade: _________________________________
Address:________________________________
____
Name of Insured: _______________________
Home phone number: ___________________
Parents' names: _________________________
Contact e-mail address: ________________

Primary Care Physician: ___________________
Physician Phone Number: __________________
Physician Fax Number: ____________________
Insurance Company*: _____________________
Ins. Co. Phone No.: _______________________
Member ID: ____________________________
Group No.: _____________________________
Insured's SSN: __________________________
DOB of Insured: _________________________
Employer of Insured: _____________________
Insured's address & phone (if diff. from pt.):
____

Client's relation to insured: Self Child Spouse Other: ______________________
Mother's work phone number: _____________ Mother's cell phone number: _______________
Father's work phone number: _____________ Father's cell phone number: _______________

*** Please include a front and back copy of your insurance and driver's license with this form.**

MEDICAL HISTORY:

Pregnancy/Delivery:

Type of delivery: Vaginal Caesarian
Gestational weeks at birth: ____weeks Birth weight: _____lbs.,______ozs.
Complications during pregnancy (i.e., preeclampsia, bed rest, etc.): ______________________
____
Complications at birth: ____
Apgar scores: ____
Feeding concerns (i.e., difficulty with taking to the breast/bottle, failure to thrive): ___________
____
Other Information: ____
____

Medical:

	Description	Date/Year	Treatment	Complications
Illnesses:				
Injuries:				
Operations:				

Number of Ear Infections: ____________ Ages when occurred: ___________________________
Treatment for ear infections (i.e., PE Tubes, antibiotics): ______________________________

Diagnoses (i.e., autism, PDD, Cerebral Palsy, epilepsy, cleft palate, syndromes): __________
____
Date of Diagnosis: __________________________ Diagnosed by?: ________________________
Special programs/services (i.e., PPCD, ABA Therapy, OT, PT, Orthodontics): ______________
Where?: ____
Allergies: ___________________________________ Date Tested: _________________________
Diet modifications: ____
Medications currently taking: ____
Hearing: Date Tested: ______________________ Results: _________________________
Vision: Date Tested: ______________________ Results: _________________________
Other Information: ____

Speech Development:

Age client spoke:

First word:______________________ Two-word combinations: ____________________________
Sentences: _____________________ Conversations: __________________________________
Counting 1-10: _________________ Initiating conversations with others: _________________

Age when client was able to:

Identify 5 colors: _________________________ Follow 2-step directions: __________________
Other Information: ____
Description of current speech problem:____
____
Severity of problem: Severe Moderate Mild
Age problem first noticed:____
Has the client ever been evaluated for speech therapy? Yes No
Date of evaluation:___________________ Therapist's name/Company:________________
Has the client received speech therapy? Yes No
Dates: ______________________________ Therapist's name/Company:________________
How much of the client's speech is understood by:
Familiar persons? _______% Unfamiliar persons? ________%
Language(s) spoken in the home: ____
Language(s) spoken by caregivers:____

Physical Development:

Age client achieved the following developmental skills:

Sit: ______________ Crawl: ___________ Walk: __________ Bladder Control: ____________
Feed self: __________________________ Dress self: _______________

Feeding/Swallowing:

Eating habits (i.e., grazer, eats large/small quantities, eats 3 meals/day, etc.): ______________
____
Is the client a "picky" eater? Yes No
List preferred foods: ____
Preferred textures/temperatures:____
Non-preferred foods: ____
Textures/temperatures avoided by client: ____
What is the client's reaction to non-preferred foods? ___________________________
Has the client received feeding/sensory therapy? Yes No Where?: ______________
Does the client drool? Yes No If yes: Day Night
Other Information: ____
____

Behavior at Home:
Describe any behavior which is problematic to the parent/caregiver: ______________________
____
Age problem first noticed: ____
Has the client received treatment to help resolve the problem? If so, by who and when?
____
Does the client have strong reactions to specific fears/situations (i.e. stranger anxiety, negative reaction to touch/loud noise)? Yes No Describe: ______________________________
Other Information: ____
____

Family:
Is the child adopted?: ____________________ If so, how old when adopted?: ____________
From where?: _________________________
Mother's occupation: ____________________ Father's occupation: ____________________
Child's caregiver/daycare/school: ____
Other family members that may have had speech/language problems and describe problem:
____

Signature: ______________________________ Date: _______________________