Palm Beach Speech & OT Specialists

Case History

Today's Date

Name of Person Completing this Form

Patient First Name | Middle Name | Last Name

Date of Birth | Age | Gender

Address

City | State | Zip Code

Home #: | Cell #: | Work #:

Who referred you to PBSLS?

Current School | Grade

Parent(s) Name	Occupation	Age

Mother / Father

Father / Mother

Please list other children in the family:

Name	Age	Gender	School/Occupation	Grade

1.

2.

3.

Physician

Patient's Physician Name Telephone #:

Address: City: State: Zip:

Concerns

What are your major concerns with the patient? Please describe as thoroughly as possible.

When did you first have these concerns?

What techniques or strategies have you tried, if any?

Birth History

This child is our: ☐ biological ☐ foster ☐ adopted

What was the mother's age at the time of this pregnancy?

What was the father's age at the time of this pregnancy?

If any, please list any medical problems BEFORE this pregnancy.

Did the mother take any prescription/nonprescription medications during this pregnancy.

If any, please list any medical problems DURING this pregnancy.

This pregnancy was: ☐ full term ☐ premature number of months_____

This delivery was: ☐ normal ☐ cesarean/breech ☐ forceps used

Was the mother given any drugs during labor and delivery? Describe:

Child's weight at birth? Any birth injuries?

Please describe any medical attention received following pregnancy. _____

_____

Medical History

Describe any illnesses, accidents, injuries, operations, and/or hospitalizations of the child (include the child's age and length of stay if hospitalized):_____

_____

_____

Has the child been given any medical diagnosis/diagnoses: _____

_____

_____

The child's current health is ☐ good ☐ fair ☐ poor

Is the child currently receiving any medical treatment?_____If yes, what?_____

_____

Is the child currently taking any medications, supplements, etc._____If yes, please list____

_____

Prescribed by whom?_____

Daily Behavior

Does the child get along with other children?_____

Does the child prefer to play alone?_____

What games and toys does the child prefer?_____

_____

How long is the child's attention span?_____

What is the child's activity level? _____

_____

How many hours a day does the child watch television, videos, or electronics?_____

_____

What does the child like to watch or play on electronics?_____

_____

Check any that apply to the child:

Problem	Yes	No	Explain
Eating	☐	☐	
Sleeping	☐	☐	
Toileting	☐	☐	
Concentrating	☐	☐	
Disciplining	☐	☐	
Activity	☐	☐	
Senses	☐	☐	
Personality	☐	☐	
Emotions	☐	☐	
Behavior	☐	☐	

Occupational Therapy History

Please provide the child's age when:

Sat alone _____
Self fed _____
Crawled _____
Walked alone _____
Toilet trained _____

Is the child sensitive to and if so, describe response to the following:

Touch_____
Taste _____
Smell _____
Sounds _____
Sight _____
Movement_____

Any concerns with the child's motor development?_____

Feeding History

The child was ☐ breast fed ☐ bottle fed

Did the infant have feeding difficulty?_____If yes, describe_____

Did the infant have swallowing or choking difficulty?_____If yes, describe_____

Is the child a picky eater?_____If yes, describe_____

Speech and Language History

Was the child responsive as an infant (respond to name, smile, laugh appropriately)?_____

If no, please explain_____

_____

Did the child babble and then stop? ☐ Yes ☐ No

Age child produced his/her first sounds_____ Examples_____

Age child produced his/her first words_____ Examples_____

Age child produced his/her first phrases_____ Examples_____

Age child produced his/her first sentences_____ Examples_____

Age of child when you were first concerned about his/her speech_____

What caused the concern?_____

_____

How does the child communicate at the present time? Provide examples of present speech:

_____

The child can be understood by ____Mother _____Father _____Relatives _____Others

Does any other member of the family have a speech or hearing problem?_____If yes, what

is the relationship of this family member to the child?_____

What is the problem?_____

What is the main language spoken within the home?_____Any other languages spoken?_____

What language does your child prefer to speak?_____

Is your child having difficulty in any other areas aside from speech?_____If yes, please explain_____

Has the child ever received speech-language therapy?_____If yes, when?_____ and what were the goals of therapy?_____

_____

Hearing History

Does the child have a history of ear infections or otitis media?_____

If yes, how many recurrences of ear infections? _____How long did each one last?_____

What medications were prescribed if any?_____

Has the child ever been treated by an Ears, Nose, Throat doctor (ENT)?_____If yes, when? _____, name of ENT_____

Has the child ever had tubes in his/her ears?_____If yes, when?_____and by whom?_____

Does your child seem over-sensitive to noise?_____If yes, please explain_____

_____

Have you ever wondered if your child can hear normally?_____

Has your child had a hearing test?_____If yes, when?_____

Does your child wear hearing aids?_____If yes, who is the audiologist?_____

Additional Comments or Concerns

Would the child separate for a diagnostic evaluation and/or therapy?_____

What skills/goals would you like for you child to achieve in therapy? _____

_____

_____

_____

_____

_____

Any additional comments or concerns you would like to express?

_____

_____

_____

_____

_____

_____

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