



Palm Beach Speech-Language 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
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Mother

Father

Please list other children in the family:

Name	Age	Gender	School/Occupation	Grade
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1.

2.

3.

Physician

Patient's Physician Name Telephone #:

Address: City: State: Zip:

What is your concern with the patient? Please describe as thoroughly as possible.

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

Length of labor?

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. _____

Developmental History

Please provide the child's age when: Sat alone _____

Self fed _____

Walked alone _____

Toilet trained _____

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 _____

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 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? _____

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): _____

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? _____

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? _____

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? _____

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			

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

Additional Comments or Concerns
