SUMMIT INC SPEECH THERAPY

CHILD CASE HISTORY

To expedite treatment, please fill out this form as completely as possible.

Section 1 Client Demographics

Person filling out form:_____ ***Relationship to child:***_____ ***Date:***_____

*Child's Name:*_____ *DOB:*_____ *Age:*_____ *Gender: F M*

*Parents or Guardians:*_____

*Phone: home:*_____ *cell:*_____ *work:*_____

*Best time to call:*_____ *Email:*_____

*Address:*_____

*City:*_____ *State:*_____ *Zip:*_____

*Reason for referral:*_____

_____

_____

*Referring person:*_____

Section 2 Home and Family

Who doe the child live with?: Both Parents Father Mother Other_____

Brothers and Sisters (include names and ages): _____

_____

What language(s) does the child speak? What is the child's primary language?_____

_____

What languages are spoken in the home? What is the primary language spoken?_____

_____

_____

Other adults living in the home: _____

_____

_____

With whom does the child spend most of his or her time? _____

_____

_____

Section 3 History of Problem

Who noted the present problem?_____

When?_____ Is your child aware of the problem?_____

If, yes, what is his or her reaction?_____

_____

How does the family react to the problem?_____

_____

What do you think may have caused the problem? _____

_____

_____

Has there been any significant change in the last six months?_____ If so, what?_____

_____

_____

How does your child usually communicate (gestures, single words, phrases, sentences)_____

_____

_____

How well is your child understood by: (i.e., what percentage of the time) Mom:_____ Dad:_____

Younger siblings:_____ Older siblings:_____ Other children:_____ Extended family:_____

Unfamiliar adults:_____

Describe what it is like to have a conversation with your child:_____

_____

_____

_____

_____

Any previous speech and language assessments? Y N Where?_____

By whom?_____ What kind?_____

What were the results?_____

_____

_____

Which tests were given?_____

_____

Any previous therapy? Y N Where?_____

With whom?_____

Have any other specialists (psychologists, physicians, special education teachers, etc. seen the child?) If yes, what were the results and recommendations?

_____

_____

_____

_____

_____

Section 3 Patient Health History

Birth History

What was the length of the pregnancy?_____

Were there any illness or accidents during the pregnancy? (explain) _____

_____

_____

Were drugs or alcohol used during pregnancy? (aspirin and/or other medication) Y N If so, what?_____

_____

_____

What was the length of labor?_____ Any difficulties at birth, including Caesarian? (describe):_____

_____

_____

_____

_____

Were drugs used?_____ Instruments?_____ Bruises to head? _____

What was the mother's age?_____ Mother's health at the time of pregnancy and birth was: _____

_____

_____

_____

Any jaundice? Y N cyanosis? Y N Rh incompatibility factors? Y N

Medical History

Please mark if you have had any of the following:

____ Seizures	____High fevers	____Measles	____Encephalitis
____Chicken Pox	____Whooping cough	____Diphtheria	____Mumps
____Pneumonia	____Tonsilitis	____Meningitis	____Bronchitis
____Rheumatic fever	____Tuberculosis	____Sinusitis	____Chronic colds
____Enlarged glands	____Thyroid	____Asthma	____Heart trouble
____Chronic Laryngitis	____Diabetes	____Head injuries	____Hearing Loss

For items marked above, give the relevant details (e.g. dates, how frequent and/or how severe are the episodes?): _____

_____

_____

_____

_____

_____

_____

_____

Recurrent earaches/ear infections? Y N Describe: _____

_____

Are immunizations current?_____Current general health? _____

Allergies? (Describe) _____

_____

Any other serious or recurrent illnesses? / When? _____

_____

_____

_____

Any operations or accidents? / When? _____

_____

_____

Hearing difficulties?_____

If so, Aided?_____

Vision problems?_____

If so, treatment? _____

Dental problems :_____

Treatment: _____

Dominant hand: Left Right Other Medical History: _____

_____

_____

Personal Medical Information

Personal Primary Physician:_____ Date of last visit:_____

Address or Location:_____

Ongoing Medical Care (Describe):_____

_____

_____

_____

Current Medications: **Dosage:** **Physician:** **Reason:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

Chronic Health Problems (Asthma, Congenital Defects, etc.):_____

_____

_____

_____

_____

Section 5 Developmental History

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed)

sat up alone_____ crawled_____ walked_____ toilet trained_____ dressed self _____

tied shoes _____ fed self independently_____

Attention span-for self-directed activities:_____

Eating and sleeping patterns:_____

Does your child respond to: Light?_____ Sound? _____ People? _____

Does your child: Play with others? _____ Who?_____

_____

Eat and sleep well? _____ Cry appropriately?_____ Laugh?_____ Smile?_____

Make wants known? _____ How? _____

_____

_____

Does your child show unusual behavior (explain)? _____

_____

_____

_____

_____

_____

Age when your child spoke first word: _____ combined words:_____ spoke in sentences: _____

Which sounds (if any) are incorrect? _____

_____

How many words can your child say? (list the words if fewer than fifteen) _____

_____

_____

How long are your child's sentences? _____

Does your child have any difficulty understanding you? (describe) _____

_____

_____

_____

Any speech or hearing problems in the immediate or extended family (explain)? _____

_____

_____

_____

_____

Section 6 Social Development:

Moves prior to age 10: _____

_____

Has your child attended day care? _____ Preschool? _____

Number or regular playmates:_____ Ages:_____ Genders: _____

Activities shared with parents and siblings: _____

_____

_____

How does your child handle frustration: _____

_____

conflict: _____

_____

seperation: _____

_____

Regular responsibilities: _____

_____

Favorite places: _____

Favorite people: _____

Favorite toys: _____

Favorite snacks: _____

Favorite activities: _____

Favorite TV programs: _____

What motivates your child most? _____

_____

What discipline methods work best? _____

_____

School experience: _____

_____

How does your child's teacher describe his/her performance? _____

_____

_____

Has the teacher expressed any concern? Y N If so, what? _____

_____

_____

Section 7 General

What do you hope to have happen as a result of this evaluation? _____

_____

_____

_____

_____

Does the report need to be sent to specific agencies? Y N Where? _____

_____

_____

Insurance Information

Primary Insurance:_____ Policy/Group#_____ Phone#_____

Subscribers name:_____ DOB:_____ Relationship:_____

Secondary Insurance:_____ Policy/Group# _____ Phone# _____

Subscribers name:_____ DOB: _____ Phone#_____

Place of Employment:_____ Employers Phone#_____

Please use the following space to expound on previous sections or to tell us any other information you would like us to know:

_____

_____

_____

_____

_____

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_____