Hackensack Meridian *Health*
Mountainside Medical Center

CASE HISTORY FORM—Pediatrics

Please fill this form out as completely as possible. This will assist the speech-language pathologist in performing the most comprehensive and appropriate evaluation of the child's speech and language skills.

Date of Evaluation:	
Child's Name:	
Date of Birth:	
Sex:	☐ **Male** ☐ **Female**
Information Given By(write name)	
Relationship to Child:	☐ Mother ☐ Father ☐ Guardian ☐ Grandparent ☐ Other specify for other:
Address:	
Phone Numbers:	**Home:** **Cell:**
	Work: **Other:**
Child's Pediatrician:	
Pediatrician's Address:	
Referred By:	

1. STATEMENT OF PROBLEM

Why is the child here for an evaluation?

_____
_____
_____
_____

When was the problem first noticed? (Please provide the time frame and/or age)

_____
_____

Has the child ever received speech therapy or had a speech/language evaluation? ☐ YES ☐ NO
If *YES*, Place of therapy/Evaluation: _____
Length of time in therapy: _____
Goals of therapy: _____

2. BIRTH HISTORY

Is your child adopted? ☐ YES ☐ NO
How old was the child when adopted? _____
Country of Birth: _____
Length of pregnancy? _____
Child's Birth weight: _____ pounds ____ ounces
Describe any unusual problems during this pregnancy or with the delivery:

_____
_____

CONDITIONS FOLLOWING BIRTH (INDICATE YES/NO):

Respiratory/breathing problems ☐ YES ☐ NO
Blue Coloring ☐ YES ☐ NO
Jaundiced ☐ YES ☐ NO
Convulsions ☐ YES ☐ NO
Scars, bruises ☐ YES ☐ NO

If *YES* to any of the above questions, please briefly explain and provide what treatment was given:

_____
_____
_____

MOTOR DEVELOPMENT

Was your child an active baby? ☐ YES ☐ NO

At what age did your child:

Milestone	**Age**
Sit	
Crawl	
Walk	

Which hand does the child prefer for?

Throwing: ☐ Right ☐ Left ☐ N/A
Eating: ☐ Right ☐ Left ☐ N/A
Drawing/Writing: ☐ Right ☐ Left ☐ N/A
Is your child well-coordinated? ☐ YES ☐ NO
Does the child fall frequently? ☐ YES ☐ NO
Is your child toilet trained? ☐ YES ☐ NO At what age was training completed? _____

MEDICAL HISTORY

Has your child ever been seen by: (check all that apply)

☐ Neurologist
☐ Pediatric Development Specialist
☐ Pulmonologist
☐ Ear, Nose, and Throat Doctor
☐ Gastroenterologist

Please indicate reasons for visit and outcome:

_____
_____

Does your child have any medical diagnosis (example: mental retardation, pervasive development disorder, Attention Deficit Disorder, etc.)

☐ Yes ☐ No

If yes, please list diagnosis:

_____
_____

What has been the child's general health condition (*please circle one):*

Poor Fair Good Excellent

Has your child had any hospitalizations? □ Yes □ No
If yes,

Date of Hospitalization	Length of Hospitalization	Reason

Is your child currently taking any medications? □ YES □ NO
If *YES*, Please provide the medication name and dosage below

Medication Name	Reason for Medication	Dosage

Has your child had any *(please indicate yes/no)*:

Pneumonia episodes?	□YES	□NO
Fainting Spells?	□YES	□NO
Bronchitis?	□YES	□NO
Convulsions/seizures?	□YES	□NO
Frequent colds?	□YES	□NO
Upper respiratory infections?	□YES	□NO
Visual Problems?	□YES	□NO
Ear Infections?	□YES	□NO
Allergies?	□YES	□NO

If *YES* to any of the above information, please provide briefly provide additional information:
_____
_____

SOCIAL HISTORY

Please list names of **all** of the people who live in the house with child being evaluated:

_____ *Relationship:* _____
_____ *Relationship:* _____
_____ *Relationship:* _____
_____ *Relationship:* _____
_____ *Relationship:* _____

Please list brothers'/sisters' names and ages:

Name	Age	Grade	Speech/Language problems
			□ YES □ NO If yes describe:
			□ YES □ NO If yes describe:
			□ YES □ NO If yes describe:
			□ YES □ NO If yes describe:
			□ YES □ NO If yes describe:

Does your child attend school or daycare? □ YES □ NO

- Name of School: _____
- Grade: _____
- Location of school: _____
- Days/Times of week in school:_____

Please describe your child's personality. _____
_____
_____

What are your child's social interactions like with other children? _____
Other adults? _____

Is your child involved in any extracurricular programs? *(gym, music, play group):* □ YES□ NO
If YES, please list activities: _____
_____

Describe what activities your child enjoys participating in: _____
_____

How much discipline is necessary and how is it administered? _____
_____

FEEDING HISTORY

Were there any feeding, chewing, or swallowing problems present shortly after birth?□ YES □ NO
If *YES*, please describe briefly: _____
_____
_____

Are there currently any feeding, chewing or swallowing problems? □ YES □ NO
If *YES*, please describe briefly: _____
_____
_____

Does the child drool now? □ YES □ NO
Is the child a mouth breather? □ YES □ NO
Was the child breast or bottle fed? □ Breast fed □ Bottle Fed
At what age was your child weaned? _____
Does the child drink from an open cup? □ YES □ NO
Use a straw? □ YES □ NO
Does your child suck his/her thumb? □ YES □ NO
Does your child use a pacifier? □ YES □ NO

At what age did the child?

Begin eating solid foods: _____
Begin eating finger foods: _____
Can the child self-feed with a spoon? □ YES □ NO

Can your child self-feed with a fork? □ YES □ NO At what age did this begin? _____
Has the child had frequent vomiting? □ YES □ NO
Does your child have a history of reflux? □ YES □ NO
If *YES*, is he/she taking any medications to treat this and what are the medications?
_____
_____

SPEECH AND LANGUAGE HISTORY

During the first year of life, other than crying was your baby (*please circle one)*:
Silent Very Quiet Average Noisy Very Noisy

How old was your child when he/she said:
First words_____
Two word combinations_____
Complete sentences_____

At what age did the child start pointing to objects/people? _____
Was it easy to understand the child's early speech? □ YES □ NO
How well do parents understand the child's speech now? □ Excellent □ Fair □ Not Easily
How well do other adults understand the child? □ Excellent □ Fair □ Not Easily
Did your child's language learning ever appear to stop for a period of time? □ YES □ NO
(If *YES*, please describe) _____
_____
Is there any history of speech/language problems in the family? □ YES □ NO
If *YES*, please provide relation and speech problem: _____
_____
Do you feel the child is aware of any speech/language problem? □ YES □ NO
Do you feel the child is self-conscious about a speech/language problem? □ YES □ NO
Does the child stammer or stutter? □ YES □ NO
Does the child's voice (pitch, volume, quality) sound like other children's voices? □ YES □ NO
Is the child's voice *(please circle)*?
Normal Soft Very low Hoarse Nasal

Is the child able to follow directions well? □ YES □ NO
Does the child have any difficulty understanding speech? □ YES □ NO
How does the child communicate with you (Circle One)?
GESTURES *POINTING* *CRYING* *TALKING*

How do you know when your child is hungry, angry, or frustrated? _____
_____
Are there any other languages other than English spoken in the home? □ YES □ NO
If yes, please list. _____
Which language does the child use/respond to better? _____

HEARING HISTORY

Has your child's hearing ever been tested by an Audiologist? □ YES □ NO
Date of Evaluation: _____ Place of Evaluation: _____
If *YES*, briefly describe the results.
_____

Has your child had any?

Hearing problems? □ YES □ NO Ear infections? □ YES □ NO

If *YES*, how often? _____

Does your child have tubes in his/her ears? □ YES □ NO Date of placement: _____

Is your child currently being treated for his/her ear infections? □ YES □ NO

GOALS

Please describe your goals for this evaluation or treatment if your child is recommended for speech/language therapy: _____

_____

_____

OTHER

Is there any additional information which you feel will help us understand your child's problems, please describe. _____

_____

_____

_____

_____

AVAILABILITY:

Please indicate the days/times you are available to bring your child if he/she is recommended for speech/language therapy:

	Monday	Tuesday	Wednesday	Thursday	Friday
9-11:30am					
1-3:30pm					
3:30-5pm					
After 5pm					