Client Case History Form

IDENTIFYING INFORMATION

Child's Legal Name: _____ Date of Birth: _____ □ Male □ Female

Address: _____

Preferred Phone: _____ Preferred Email Address: _____

Primary Concern for treatment: _____

BIRTH & MEDICAL HISTORY

How many weeks gestation was child at birth? _____ Birth Weight _____ Birth Length _____

Were there any complications during pregnancy? □ Yes □ No If yes, please describe: _____

_____

Type of Delivery: □ Vaginal □ Cesarean Were there complications during or following birth? □ Yes □ No

If yes, please describe: _____

How long was the hospital stay after birth? _____ If extended, please explain: _____

_____

Hospitalizations and Dates: _____

Surgeries and Dates: _____

Allergies: _____

Medications, Dosage, and Reasons: _____

Please list any significant medical diagnoses or illnesses? _____

_____

Does your child have a history of any of the following:

Frequent Respiratory Infections	□ Yes □ No	Frequent Ear Infections	□ Yes □ No
Oxygen Requirements	□ Yes □ No	Unexplained High Fevers	□ Yes □ No
Constipation	□ Yes □ No	Vomiting	□ Yes □ No
Difficulties Sleeping	□ Yes □ No	Headaches	□ Yes □ No
Seizures	□ Yes □ No	Developmental Disorder	□ Yes □ No

If you responded yes to any of the above, please explain: _____

_____

Recent Hearing Screening Date: _____ Results: _____

Recent Vision Screening Date: _____ Results: _____

DEVELOPMENT HISTORY

Please write the age (in months) when your child achieved the following:

Push up on Tummy	_____	Hold Head Up	_____
Roll Over	_____	Sit Unsupported	_____
Crawl	_____	Pull to Stand	_____
Cruise	_____	Walk Independently	_____

Do you have any concerns about your child's motor development? □ Yes □ No If yes, describe: _____

_____

Please write the age (in months) at which your child began each of the following:

Smile	_____	Coo	_____
Babble	_____	Laugh	_____
Use Simple Gestures (wave, up)	_____	Imitate Speech Sounds	_____
Say Mama, Dada, Exclamations	_____	Use First Word	_____
Combine Two Words	_____	Speak in Sentences	_____

Does your child do any of the following?

Smile at People	□ Yes □ No	Attend to Faces	□ Yes □ No
Like to Play with people	□ Yes □ No	Copy Movements or Facial Expressions	□ Yes □ No
Track Moving Objects with Eyes	□ Yes □ No	Reach for Toys	□ Yes □ No
Look at Self in Mirror	□ Yes □ No	Respond to Name	□ Yes □ No
Pass Objects Between Hands	□ Yes □ No	Understand No	□ Yes □ No
Point at Things	□ Yes □ No	Play Peek-A-Boo	□ Yes □ No
Repeat Actions for Attention	□ Yes □ No	Follow 1-Step Verbal Commands	□ Yes □ No
Point to Items or Pictures	□ Yes □ No	Name Pictures	□ Yes □ No
Ask Questions	□ Yes □ No	Answer Questions	□ Yes □ No

Primary Language: _____ Percentage Exposed: _____

Does your child understand the language? □ Yes □ No Does your child use the language? □ Yes □ No

Secondary Language: _____ Percentage Exposed: _____

Does your child understand the language? □ Yes □ No Does your child use the language? □ Yes □ No

Tertiary Language: _____ Percentage Exposed: _____

Does your child understand the language? □ Yes □ No Does your child use the language? □ Yes □ No

Describe how your child primarily communicates (reaching, pointing, gestures, signs, words, phrases, conversation, etc.): _____

_____

Does your child become frustrated by his/her difficulty communicating? □ Yes □ No If yes, explain: _____

_____

How much of what your child says do YOU understand? _____%

How much of what your child says do UNFAMILIAR people understand? ____%

Describe types of directions your child follows: _____

_____

Describe types of questions which your child responds: _____

_____

Please check any of the following characteristics that apply to your child:

□ Attentive	□ Cooperative	□ Easily engaged in activities
□ Friendly	□ Transitions easily	□ Plays well with peers
□ Poor eye contact	□ Withdrawn	□ Easily distracted
□ Impulsive	□ Separation Difficulties	□ Stubborn
□ Easily frustrated	□ Aggressiveness	□ Temper tantrums

How would you describe your child's overall behavior? _____

_____

TREATMENT HISTORY

Has your child received a speech-language evaluation previously? _____ If yes, when? _____

What were the results? _____

Has your child received a speech-language therapy previously? _____ If yes, when? _____

Where? _____ What was addressed? _____

Has your child received any other therapies (PT, OT, ABA) previously or currently? _____

If yes, please provide more information regarding the type of therapy, when, where, and goals addressed:

_____

EDUCATION HISTORY

Does your child attend childcare center or school? □ Yes □ No If yes, where? _____

Address of childcare center or school: _____

How many days a week? _____ How many hours per day? _____ What grade is your child? _____

Does your child have an IFSP or IEP? □ Yes □ No

Please provide relevant details or information regarding your child's educational programming or schedule:

_____

FEEDING HISTORY

How was your child initially fed? Breast _____ Bottle _____ Breast and Bottle _____ Tube_____

What did your child initially drink? Breastmilk _____ Formula _____ (Brand:_____) Both _____

Were there difficulties with early drinking? □ Yes □ No If Yes, please describe: _____

At what age was a bottle introduced? _____ Were there difficulties transitioning to a bottle? □ Yes □ No

If Yes, please describe: _____

At what age was a cup introduced? _____ Were there difficulties transitioning to a cup? □ Yes □ No

If Yes, please describe: _____

What mode does your child currently drink from? _____ How many ounces are consumed at a sitting? _____

How many minutes does it take your child to consume a bottle or cup? _____

What liquids does your child currently drink? _____

How is your child positioned during drinking? _____

Do you have any concerns regarding your child's current drinking skills? □ Yes □ No If yes, please describe:
_____

Do any of the following pertain to your child's feeding history:

Frequent Gagging	□ Yes □ No	Frequent Coughing	□ Yes □ No
Frequent Choking	□ Yes □ No	Difficulty Chewing	□ Yes □ No
Difficulty Swallowing	□ Yes □ No	Frequent Vomiting	□ Yes □ No

Write the approximate age (in months) at which you introduced the following:

Puree foods	_____	Soft solids	_____
Meltable solids	_____	Solid foods	_____

Were there difficulties transitioning to solid foods? □ Yes □ No If Yes, please describe _____
_____

Does your child feed him/herself? □ Yes □ No How does your child eat? □ hands □ fingers □ spoon □ fork

How is your child positioned during mealtime? _____

Describe a typical daily mealtime schedule below:

Meal	Time	Foods Consumed	Liquid Consumed	Volume
Snack	_____	_____	_____	_____
Breakfast	_____	_____	_____	_____
Snack	_____	_____	_____	_____
Lunch	_____	_____	_____	_____
Snack	_____	_____	_____	_____
Dinner	_____	_____	_____	_____
Snack	_____	_____	_____	_____

How many minutes does a mealtime last? _____

Does your child consume a wide variety of food groups? □ Yes □ No If no, describe concerns: _____
_____

Does your child consume a wide variety of food textures? □ Yes □ No If no, describe concerns: _____
_____

Do you have any concerns regarding your child's current feeding skills? □ Yes □ No If yes, please describe: ___
_____

OTHER INFORMATION

What activities does your child enjoy? _____

What are your child's strengths? _____

What are your child's weaknesses? _____

What do you hope to gain from the evaluation and/or treatment? _____
_____

Please share anything else you feel is relevant to your child: _____
_____
_____
_____

Person who completed this form: _____ Relationship to client: _____

Signature: _____Today's Date: _____

Thank you for taking time to respond as accurately as possible!
This form must be printed, completed, signed, and returned
via mail or fax 855-370-5735 prior to scheduling your initial appointment.