The Speech Emporium

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GENERAL CASE HISTORY

REASON FOR EVALUATION:

_____
_____
_____

Demographic Information:

Client's name: _____
Client's date of birth: _____
Age: _____
Grade: _____
Address:_____
_____
Name of Insured: _____
Home phone number: _____
Parents' names: _____
Contact e-mail address: _____

Primary Care Physician: _____
Physician Phone Number: _____
Physician Fax Number: _____
Insurance Company*: _____
Member ID: _____
Group No.: _____
Insured's SSN: _____
DOB of Insured: _____
Employer of Insured: _____
Insured's address & phone (if diff. from pt.):
_____

Client's relation to insured: Self Child Spouse Other: _____
Mother's work phone number: _____ Mother's cell phone number: _____
Father's work phone number: _____ Father's cell phone number: _____

*** Please include a front and back copy of your insurance and driver's license with this form.**

MEDICAL HISTORY:

Pregnancy/Delivery:

Type of delivery: Vaginal Caesarian
Gestational weeks at birth: ____weeks Birth weight: _____lbs.,_____ozs.
Complications during pregnancy (i.e., preeclampsia, bed rest, etc.): _____
_____
Complications at birth: _____
Apgar scores: _____
Feeding concerns (i.e., difficulty with taking to the breast/bottle, failure to thrive): _____
_____
Other Information: _____
_____

Medical:

	Description	Date/Year	Treatment	Complications
Illnesses:				
Injuries:				
Operations:				

Number of Ear Infections: _____ Ages when occurred: _____
Treatment for ear infections (i.e., PE Tubes, antibiotics): _____
Diagnoses (i.e., autism, PDD, Cerebral Palsy, epilepsy, cleft palate, syndromes): _____

_____
Date of Diagnosis: _____ Diagnosed by?: _____
Special programs/services (i.e., PPCD, ABA Therapy, OT, PT, Orthodontics): _____
Where?: _____
Allergies: _____ Date Tested: _____
Diet modifications: _____
Medications currently taking: _____
Hearing: Date Tested: _____ Results: _____
Vision: Date Tested: _____ Results: _____
Other Information: _____

Speech Development:

Age client spoke:
First word:_____ Two-word combinations: _____
Sentences: _____ Conversations: _____
Counting 1-10: _____ Initiating conversations with others: _____
Age when client was able to:
Identify 5 colors: _____ Follow 2-step directions: _____
Other Information: _____
Description of current speech problem:_____
_____
Severity of problem: Severe Moderate Mild
Age problem first noticed:_____
Has the client ever been evaluated for speech therapy? Yes No
Date of evaluation:_____ Therapist's name/Company:_____
Has the client received speech therapy? Yes No
Dates: _____ Therapist's name/Company:_____
How much of the client's speech is understood by:
Familiar persons? _____% Unfamiliar persons? _____%
Language(s) spoken in the home: _____
Language(s) spoken by caregivers:_____

Physical Development:

Age client achieved the following developmental skills:
Sit: _____ Crawl: _____ Walk: _____ Bladder Control: _____
Feed self: _____ Dress self: _____

Feeding/Swallowing:

Eating habits (i.e., grazer, eats large/small quantities, eats 3 meals/day, etc.): _____
_____
Is the client a "picky" eater? Yes No
List preferred foods: _____
Preferred textures/temperatures:_____
Non-preferred foods: _____
Textures/temperatures avoided by client: _____
What is the client's reaction to non-preferred foods? _____
Has the client received feeding/sensory therapy? Yes No Where?: _____
Does the client drool? Yes No If yes: Day Night
Other Information: _____
_____

Behavior at Home:

Describe any behavior which is problematic to the parent/caregiver: _____

_____

Age problem first noticed: _____

Has the client received treatment to help resolve the problem? If so, by who and when?

_____

Does the client have strong reactions to specific fears/situations (i.e. stranger anxiety, negative reaction to touch/loud noise)? Yes No Describe: _____

Other Information: _____

_____

Family:

Is the child adopted?: _____ If so, how old when adopted?: _____

From where?: _____

Mother's occupation: _____ Father's occupation: _____

Child's caregiver/daycare/school: _____

Other family members that may have had speech/language problems and describe problem:

_____

Signature: _____ Date: _____