The Speech Path
Your PATH to success starts here.

Occupational Therapy
Physical Therapy
Speech Therapy

GENERAL CASE HISTORY

Patient's Name:		Date:
Date of Birth:	Age:	Grade Level:
Name of School Currently Attending:		
Parent/Guardian Names:		
Phone Numbers: (home)	(cell)	
Referring Physician:	Pediatrician, if different than referring physician:	

REASON FOR EVALUATION (must be completed):

BIRTH HISTORY

Maternal illnesses/complications during pregnancy:		
Mother's age at birth:	Gestational weeks at birth:	
Type of Delivery: Vaginal or Caesarian	Reason for Caesarian:	
Complications during/after delivery (forceps, vacuum, breech, jaundice, infection, breathing problems, other):		
Time in Labor:	Birth Weight:	APGAR score:
Did the child require: Ventilator (Length of time _____) or Feeding Tube (Length of time_____)		
How long was the child in the hospital after birth?		
Other information related to birth history?		

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GENERAL CASE HISTORY (CONT'D)

Medical Diagnosis(es): (Anxiety, Asperger's, Autism, Scoliosis, Learning Disorder, Rett Syndrome, Down's Syndrome, Developmental Disorder, Sensory Disorder, Feeding Disorder, etc.)

Allergies: (Medication allergies, Latex, Food, etc.)		
Current Weight: _____	Current Height: _____	Head Circumference: _____

Has the child had an EYE EXAM? Y/N Date: Results:
Has the child has a HEARING TEST? Y/N Date: Results:
Has the child had IMMUNIZATIONS? Y/N Yes, some: Yes, up to date: Y/N
Has the child had any REACTIONS TO IMMUNIZATIONS? Y/N Explain:
Does the child have frequent EAR INFECTIONS? Y/N Has PE Tubes? Y/N Date of Tubes placement:
Does the child have frequent COLDS? Y/N Number per year:
Has the child ever had a high fever (>102 degrees F)? Y/N Explain:

Please list any Hospitalizations, Major Injuries/Accidents, Surgeries and/or Major Illnesses, DATE AND EXPLANATION:

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List any other Specialist/Physician (Orthopedist, Neurologist, etc.) the patient sees (Name and Specialty):

List any special services the patient receives (Babies Can't Wait, Special Education, Georgia Cyber Academy, etc.):

List any current PRESCRIBED and OVER THE COUNTER medication the patient is taking:

Other information related to Medical History:

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PHYSICAL DEVELOPMENT

Does the patient: Age Achieved:

Sit Unsupported Y/N	
Crawl Y/N	
Walk Y/N	
Feed Self with Spoon Y/N	
Dress Self Y/N	
Control his/her Bladder Y/N	
Bathe Self Y/N	

FEEDING DEVELOPMENT

Is/Was the patient breastfed? Y/N How Long:
If currently breastfeeding: How long? Schedule?
Did/Does the patient take formula? Y/N Type: Amount:
If currently taking formula: Amount? Schedule?
Did the patient experience Colic? Y/N
Did/Does the patient take a pacifier? Y/N What style/brand(MAM, Dollarstore, NUK, etc.):
The patient currently drinks from a (choose one): Bottle Sippy Cup Regular Cup Straw Other
Does the patient eat jar foods? Y/N Any issues transitioning to jar food? Y/N Stage I Stage II Stage III Graduates Table Foods:
Does the patient drool excessively? Y/N
Does the patient have preferred temperatures/textures? Y/N Warm Cold Hot Room Temp Explain:

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BEHAVIOR

Does the patient: Will the patient:

Play with other children? Y/N	Swing? Y/N
Have close friends? Y/N	Slide? Y/N
Have preferred toys? Y/N	Play in a sandbox? Y/N
Play outside? Y/N	Walk barefoot in grass? Y/N

Describe any behavior that is problematic for the parent/guardian:	
Age first noticed problem:	Severity: Mild Moderate Severe

Describe any strong reactions the patient might have to specific fears/ situations:

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FAMILY/SOCIAL HISTORY

Are the patient's parents together? Y/N Explain:
How is (are) the legal guardian(s) related to the child:
Is the child adopted? Y/N Age of Adoption:
Mother's occupation: Name of business:
Father's occupation: Name of business:
Name of daytime caregiver/daycare:
Siblings/Ages:
Others living in the home:
Other family members with speech/language problems:
Other family members with physical/motor developmental problems:

SIGNATURE: _____

DATE: _____

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