



19465 Deerfield Avenue, Suite 201  
Lansdowne, Virginia 20176  
703-858-7620 VOICE & TTY  
703-858-7657 FAX

**PEDIATRIC CASE HISTORY FORM**  
***Speech-Language Pathology***

Please fill out this form as completely as possible. The information will help us understand your child's present communication problems and will aid us in planning appropriate testing procedures. ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INFORM US IF AT ANY TIME THIS INFORMATION CHANGES.

***\*PLEASE NOTE: AFTER COMPLETION, PLEASE RETURN THIS FORM, ALONG WITH ANY OTHER PERTINENT ACADEMIC/MEDICAL REPORTS (e.g. IEP's, Hospital discharge summaries) TO THE CENTER AT LEAST (1) WEEK BEFORE THE SCHEDULED EVALUATION***

**I. CASE INFORMATION**

Date \_\_\_\_\_

Child's Name \_\_\_\_\_

Nickname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Grade in School \_\_\_\_\_

Father's Name \_\_\_\_\_

Mother's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

Father's Address \_\_\_\_\_

Mother's Address \_\_\_\_\_

Father's Employer \_\_\_\_\_

Mother's Employer \_\_\_\_\_

Position: \_\_\_\_\_

Position \_\_\_\_\_

Father's telephone (H) \_\_\_\_\_  
(W) \_\_\_\_\_  
(cell) \_\_\_\_\_  
email \_\_\_\_\_

Mother's telephone (H) \_\_\_\_\_  
(W) \_\_\_\_\_  
(cell) \_\_\_\_\_  
email \_\_\_\_\_

Parent's marital status: S M D W

Child lives with (check one):

\_\_\_\_\_ Birth Parents                      \_\_\_\_\_ Foster Parents                      \_\_\_\_\_ One parent  
\_\_\_\_\_ Adoptive Parents                      \_\_\_\_\_ Parent and Stepparent                      \_\_\_\_\_ Other \_\_\_\_\_

Ethnicity: African American – Asian – Caucasian – Hispanic/Latino Other \_\_\_\_\_

Primary Language Spoken in the home / by primary caregiver \_\_\_\_\_ / \_\_\_\_\_

Primary Language Spoken by child in home \_\_\_\_\_ Other Language(s) Spoken \_\_\_\_\_

Combined Income (Please check one)

Less than \$12,000 \_\_\_\_\_ \$30,000 – \$50,000 \_\_\_\_\_ \$90,000-\$120,000 \_\_\_\_\_  
\$12,000 – \$20,000 \_\_\_\_\_ \$50,000 – \$70,000 \_\_\_\_\_ over \$120,000 \_\_\_\_\_  
\$20,000 – \$30,000 \_\_\_\_\_ \$70,000 - \$90,000 \_\_\_\_\_

Please describe why you are having your child seen for a speech-language evaluation (e.g. voice, stuttering, expressive/receptive language delay, articulation, reading difficulty, etc)

---

---

How did you hear about us? (Please circle one)

Word of mouth

Phone book/yellow pages

School System

Internet

Physician/Pediatrician

Other \_\_\_\_\_

If you do not want to receive information about new services, Fundraising events or other BRSH news, please check here:

## II. FAMILY HISTORY

Please list names and ages of all people living in the home:

NAME	AGE	RELATIONSHIP
------	-----	--------------

---

---

---

---

Is this child adopted? \_\_\_\_\_ At what age? \_\_\_\_\_ Location \_\_\_\_\_ Does child know? \_\_\_\_\_

Are there any incidences of any of the following conditions among the **child's family/close relatives** (maternal and paternal)?

	Y	N	Explain
1. Speech problems	_____	_____	_____
2. Hearing problems	_____	_____	_____
3. Learning disabilities	_____	_____	_____
4. Seizures/convulsions	_____	_____	_____
5. Mental retardation	_____	_____	_____
6. Heart disease	_____	_____	_____
7. Autism/spectrum disorder	_____	_____	_____

## III. BIRTH HISTORY

During pregnancy, did mother:

	Y	N
1. enjoy anything other than good health?	_____	_____
2. contract any diseases?	_____	_____
3. take any prescriptions and/or drugs of any kind?	_____	_____
4. become involved in any accidents/falls?	_____	_____
5. become exposed to any X-ray treatments?	_____	_____
6. experience any abnormal bleeding episodes?	_____	_____
7. present with Rh incompatibility?	_____	_____
8. undergo amniocentesis (genetic testing)?	_____	_____
9. suffer any emotional stress?	_____	_____
10. experience any OTHER difficulties?	_____	_____
11. become exposed to rubella?	_____	_____
12. excessively consume alcohol?	_____	_____

Please explain any "Yes" answers:

---

---

---

Length of Labor: \_\_\_\_\_ Labor was: \_\_\_\_\_ spontaneous \_\_\_\_\_ induced.  
Baby was delivered: \_\_\_\_\_ Full-term \_\_\_\_\_ Premature (\_\_\_\_\_ week of gestation)  
Type of delivery: \_\_\_\_\_ Cesarean \_\_\_\_\_ Vaginal \_\_\_\_\_ Breech  
This was a: \_\_\_\_\_ single birth \_\_\_\_\_ multiple birth (twins, triplets, etc.)  
During labor/delivery were any instruments used to assist with the birth? \_\_\_\_\_ Y \_\_\_\_\_ N  
During labor/delivery were any drugs administered? \_\_\_\_\_ Y \_\_\_\_\_ N  
If so, please list drugs given and purpose (as explained to you) \_\_\_\_\_

The baby was pronounced "healthy" at birth? \_\_\_\_\_ Y \_\_\_\_\_ N  
At birth the infant weighed: \_\_\_\_\_ APGAR scores (if known) \_\_\_\_\_.

The baby experienced difficulties breathing at birth: \_\_\_\_\_ Y \_\_\_\_\_ N  
The baby was described as a "blue baby": \_\_\_\_\_ Y \_\_\_\_\_ N  
The baby experienced some jaundice: \_\_\_\_\_ Y \_\_\_\_\_ N  
The baby was placed on a feeding tube: \_\_\_\_\_ Y \_\_\_\_\_ N  
Mother and infant were discharged separately from hospital: \_\_\_\_\_ Y \_\_\_\_\_ N

Please explain any "Yes" answers: \_\_\_\_\_

Did child experience any early feeding/swallowing problems (weak suck, turning "blue" while attempting to nurse, projectile vomiting, choking, lack of appetite, early fatigue, milk coming out nose while nursing, etc.)? \_\_\_\_\_

#### **IV. MEDICAL HISTORY**

Child's pediatrician/Family doctor \_\_\_\_\_  
Address \_\_\_\_\_

Please list any medications your child takes regularly (including medication for behavior or attention control).  
***Please include purpose of medication.***

Is your child currently (or recently) under a physician's care? \_\_\_\_\_ If yes, **why?** \_\_\_\_\_

Does your child have any known allergies to food or to his/her environment? \_\_\_\_\_ Y \_\_\_\_\_ N If yes, please list.

Is there a family history of allergies? \_\_\_\_\_ Y \_\_\_\_\_ N If yes, please list.

Has your child been exposed to nuts? \_\_\_\_\_ Y \_\_\_\_\_ N

Is your child's immunization record up to date? \_\_\_\_\_ Y \_\_\_\_\_ N

Does child have any medical diagnoses? (e.g., ADD, autism, dyslexia) \_\_\_\_\_ Y \_\_\_\_\_ N If yes, please list and state name of doctor who gave the diagnosis.

Does child have a history of ear infections? \_\_\_\_\_ Y \_\_\_\_\_ N (If yes, please list how many/dates) \_\_\_\_\_  
P/E tubes? \_\_\_\_\_ Y \_\_\_\_\_ N \_\_\_\_\_  
frequent colds/ sinus infections? \_\_\_\_\_ Y \_\_\_\_\_ N \_\_\_\_\_  
bronchitis/pneumonia? \_\_\_\_\_ Y \_\_\_\_\_ N \_\_\_\_\_  
drainage from ear? \_\_\_\_\_ Y \_\_\_\_\_ N \_\_\_\_\_  
tonsils/adonoids removed? \_\_\_\_\_ Y \_\_\_\_\_ N (If yes, when?) \_\_\_\_\_  
breathing difficulties/asthma? \_\_\_\_\_ Y \_\_\_\_\_ N \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Significant results \_\_\_\_\_  
 Date of last hearing test \_\_\_\_\_ Please give agency, date and results \_\_\_\_\_  
 Describe any auditory problems \_\_\_\_\_  
 Date of last vision test \_\_\_\_\_ Significant results \_\_\_\_\_  
 Describe any vision problems \_\_\_\_\_  
 If child wears glasses, when are they to be worn? \_\_\_\_\_

Has child experienced any of the following? Please explain all "yes" responses below:

	Y	N
1. Visual difficulties	_____	_____
2. High fevers lasting longer than 1 day	_____	_____
3. Seizures / Convulsions	_____	_____
4. Tuberculosis	_____	_____
5. Diphtheria	_____	_____
6. Meningitis	_____	_____
7. Chicken Pox	_____	_____
8. Mumps	_____	_____
9. Asthma	_____	_____
10. Hospitalization	_____	_____
11. Rheumatic Fever	_____	_____
12. Surgery	_____	_____
13. Heart Trouble	_____	_____
14. Anemia	_____	_____
15. Encephalitis	_____	_____
16. Head Injury	_____	_____
17. Swallowing / chewing problems	_____	_____
15. Other	_____	_____

Please explain any "Yes" answers:

---



---



---

**V. DEVELOPMENTAL HISTORY**

Did your child:

Hold his/her head up by 4 months? _____ Y _____ N	First sit alone by 12 months? _____ Y _____ N
First crawl by 12 months? _____ Y _____ N	First ate solid food by 12 months? _____ Y _____ N
First walk alone by 16 months? _____ Y _____ N	Fed self by 2 years? _____ Y _____ N
Was toilet-trained by 3 years? _____ Y _____ N	First use scissors by 3 years? _____ Y _____ N
First grasped crayon/pencil (thumb and finger) by 3 years? _____ Y _____ N	

Please describe your child's gross motor skills (coordinated, clumsy, falls a lot, slow, etc.) while walking, running, climbing, riding bikes, roller skating, etc. \_\_\_\_\_

---



---

Please describe your child's fine motor skills while attempting to color, write, draw, cut with scissors, feed him/herself with utensils, etc. \_\_\_\_\_

---



---

This child is: \_\_\_\_\_ RIGHT-handed \_\_\_\_\_ LEFT-handed \_\_\_\_\_ uses BOTH equally.

**VI. SPEECH AND LANGUAGE INFORMATION**

Did child cry normally (to communicate pain, fear, discomfort, loneliness)? \_\_\_Y\_\_\_ N How much? \_\_\_\_\_

Did your child begin: cooing/ babbling by age 4 months? \_\_\_Y\_\_\_ \_\_\_N\_\_\_ How much? \_\_\_\_\_  
 Respond to name/peek-a-boo by 8 months? \_\_\_Y\_\_\_ \_\_\_N\_\_\_  
 using jargon\* by 12 months? \_\_\_Y\_\_\_ \_\_\_N\_\_\_ How much? \_\_\_\_\_  
 imitate sounds by 12 months? \_\_\_Y\_\_\_ \_\_\_N\_\_\_

\*(Jargon is defined as words that are not understandable, but are said in “sentences,” where the child’s inflections let you know that he is “saying something.”)

saying his first word by 15 months? \_\_\_Y\_\_\_ \_\_\_N\_\_\_  
 saying 2 words together by 24 months? \_\_\_Y\_\_\_ \_\_\_N\_\_\_  
 using short sentences by 36 months? \_\_\_Y\_\_\_ \_\_\_N\_\_\_

Estimate how many words your child presently uses. \_\_\_\_\_

Has speech/language development ever been interrupted? \_\_\_\_\_ Reversed? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

Has there been a change in child’s speech/language over the last 6 months? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

How does child communicate with you? (e.g., pointing, gesturing, grunting, words) \_\_\_\_\_

How does child communicate with siblings and/or peers? \_\_\_\_\_

Please give two to three examples of your child’s comments that are typical at this time. \_\_\_\_\_

Indicate with a checkmark any items that are difficult for your child:

- Eating a variety of foods \_\_\_\_\_
- Understanding what he/she hears \_\_\_\_\_
- Following directions or routines \_\_\_\_\_
- Speaking in organized or grammatically correct sentences \_\_\_\_\_
- Answering questions \_\_\_\_\_
- Pronouncing words correctly \_\_\_\_\_
- Singing songs / reciting nursery rhymes \_\_\_\_\_
- Stating sounds of letters \_\_\_\_\_
- Recognizing “common” words \_\_\_\_\_
- Writing his/her name \_\_\_\_\_
- Rhyming \_\_\_\_\_
- Getting his/her point across \_\_\_\_\_
- Thinking of words for things \_\_\_\_\_
- Understanding concept of time (seasons, day/night, hours) \_\_\_\_\_
- Telling stories \_\_\_\_\_
- Self-calming \_\_\_\_\_
- Receiving/giving hugs \_\_\_\_\_
- Keeping shoes on \_\_\_\_\_
- Eye-Hand Coordination \_\_\_\_\_
- Using a straw \_\_\_\_\_
- Blowing bubbles \_\_\_\_\_
- Keeping hands to him/herself \_\_\_\_\_

**VII. EDUCATIONAL HISTORY**

Name of school / daycare \_\_\_\_\_  
Address \_\_\_\_\_

Please list your child's school/daycare schedule:

Monday      Tuesday      Wednesday      Thursday      Friday  
\_\_\_\_\_

Present classroom teacher / special ed. teacher / speech pathologist's name \_\_\_\_\_

Present Grade \_\_\_\_\_

Has your child been kept back at any grade level? \_\_\_\_\_ Y      \_\_\_\_\_ N      Which grade? \_\_\_\_\_  
Why? \_\_\_\_\_

Is your child currently receiving Special Education services through the school system? \_\_\_\_\_ Y      \_\_\_\_\_ N  
If yes, what is the disability code? \_\_\_\_\_ Amount of service? \_\_\_\_\_

Does he/she have a current IEP? \_\_\_\_\_ Y      \_\_\_\_\_ N (If yes, please provide copies along with this form)

Has he/she received Special Education services in the past? \_\_\_\_\_ Y      \_\_\_\_\_ N      Dates \_\_\_\_\_  
If yes, name services. \_\_\_\_\_

Indicate with a check mark any/all areas of difficulty:

speech	_____	writing sentences/paragraphs	_____
reading	_____	spelling	_____
attention	_____	study habits	_____
math	_____	fine motor (e.g. cutting, buttoning)	_____
organization	_____	handwriting	_____

What kinds of grades/reports does your child receive? \_\_\_\_\_  
Describe your child's attitude toward school: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VIII. BEHAVIORAL HISTORY**

Please check all that describe your child:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Friendly                                  | <input type="checkbox"/> Impulsive/impatient      | <input type="checkbox"/> Separation difficulties         |
| <input type="checkbox"/> Easy-going                                | <input type="checkbox"/> Difficulty sleeping      | <input type="checkbox"/> Poor eye contact                |
| <input type="checkbox"/> Plays well with other children            | <input type="checkbox"/> Hyperactive              |  |
| <input type="checkbox"/> Cooperative                               | <input type="checkbox"/> Aggressive/destructive   | <input type="checkbox"/> Doesn't like to be read to      |
| <input type="checkbox"/> Attentive                                 | <input type="checkbox"/> Has temper tantrums      | <input type="checkbox"/> Poor memory                     |
| <input type="checkbox"/> Willing to try new activities             | <input type="checkbox"/> Unpredictable            |  |
| <input type="checkbox"/> Sleeps well                               | <input type="checkbox"/> Defiant                  | <input type="checkbox"/> Will not eat certain textures   |
| <input type="checkbox"/> Eats well                                 | <input type="checkbox"/> Cannot easily shift from | <input type="checkbox"/> Will not touch certain textures |
| <input type="checkbox"/> Plays alone for reasonable amount of time | <input type="checkbox"/> one activity to another  | <input type="checkbox"/> Overly sensitive emotionally    |
|  | <input type="checkbox"/> Bites nails              | <input type="checkbox"/> Doesn't like to be touched      |
|  | <input type="checkbox"/> Stubborn                 | <input type="checkbox"/> Still uses pacifier/sucks thumb |
| <input type="checkbox"/> Talkative                                 | <input type="checkbox"/> Bad-tempered             | <input type="checkbox"/> Has nightmares                  |
| <input type="checkbox"/> Clumsy                                    | <input type="checkbox"/> Cries easily             | <input type="checkbox"/> Grinds teeth                    |
| <input type="checkbox"/> Distractible/short attention span         |   | <input type="checkbox"/> Wets bed                        |
| <input type="checkbox"/> Easily frustrated                         | <input type="checkbox"/> Withdrawn                | <input type="checkbox"/> Mouth breather                  |
| <input type="checkbox"/> Restless                                  | <input type="checkbox"/> Shy                      | <input type="checkbox"/> Snores                          |
|  | <input type="checkbox"/> Quiet                    | <input type="checkbox"/> Sensitive to sounds             |
|  | <input type="checkbox"/> Daydream often           |  |

**IX. DIAGNOSTIC INFORMATION** (Please provide copies of any test results along with this form)

Date of most recent educational evaluation: \_\_\_\_\_

Date of most recent psychological evaluation: \_\_\_\_\_

Date of most recent speech-language evaluation: \_\_\_\_\_

**X. SERVICES**

Please complete the following information concerning professionals (tutors, therapists) **currently working with your child**.

<u>Service Provided</u>	<u>Name of Provider</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please complete the following information concerning professionals (tutors, therapists) who **have worked with your child in the past**.

<u>Service Provided</u>	<u>Name of Provider</u>	<u>Dates of Service</u>	<u>Why terminated?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**XI. CHILD'S INTERESTS**

Describe your child's hobbies: \_\_\_\_\_  
\_\_\_\_\_

Does your child prefer to play with children his own age, younger, older or by him/herself? \_\_\_\_\_

Approximate number of hours per week your child watches T.V.: \_\_\_\_\_

Types of shows your child watches: \_\_\_\_\_

Do you read to your child? \_\_\_ Y \_\_\_ N If yes, how often? \_\_\_\_\_

Does your child read independently for pleasure? \_\_\_ Y \_\_\_ N If yes, how often? \_\_\_\_\_

Favorite books: \_\_\_\_\_  
\_\_\_\_\_

How much playtime do you engage in with your child per day? \_\_\_\_\_

✂ Please make any other comments which you feel would be helpful or important in our endeavor to assist with your child's needs:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This form completed by:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

AUTHORIZATION FOR RELEASE OF INFORMATION

*Please complete and send back with the completed Information Form*

**I hereby authorize the use or disclosure of my individually identifiable health information as described below from \_\_\_/\_\_\_/\_\_\_ (current date) to \_\_\_/\_\_\_/\_\_\_ (maximum six months).** I understand that this authorization is voluntary and may be revoked at any time. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Person/organization(s) providing the information:**

**Blue Ridge Speech and Hearing Center – Speech-Language Pathology Evaluation**

**Other:** \_\_\_\_\_

**Persons/Organizations receiving the information:**

*(Please include any /all of the professionals involved in the care of the client for the current diagnosis for which he/she is being seen.) Please include name and phone number. This information will be used to assist in providing the most comprehensive care to the client.*

**Primary Care Physician /Pediatrician:** \_\_\_\_\_ **Address** \_\_\_\_\_

**Audiologist:** \_\_\_\_\_ **Address** \_\_\_\_\_

**G.I.:** \_\_\_\_\_ **Address** \_\_\_\_\_

**Neurologist:** \_\_\_\_\_ **Address** \_\_\_\_\_

**Physical Therapist:** \_\_\_\_\_ **Address** \_\_\_\_\_

**Occupational Therapist:** \_\_\_\_\_ **Address** \_\_\_\_\_

**Speech Therapist:** \_\_\_\_\_ **Address** \_\_\_\_\_

**Other:** \_\_\_\_\_ **Address** \_\_\_\_\_

**Name of School:** \_\_\_\_\_ **Address** \_\_\_\_\_

**Teacher:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

\_\_\_\_\_  
*Signature of client or client's representative* \_\_\_\_\_  
*Date*

**Printed name of client's representative:** \_\_\_\_\_

**Relationship to client:** \_\_\_\_\_

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

**Note: It is very important that you provide us with an address or we may not be able to forward a copy of the report to those requested.**

