ACHIEVE

Speech, Language & Executive Function Experts

SPEECH/LANGUAGE CASE HISTORY FORM

Name:________________________ Today's Date:____________________
Address:______________________ Referred by:_____________________
____

Phone: (Home)________________ Emergency contact:______________
(Work)_________________ Address:________________________
Date of Birth:___________________ ________________________
Sex:______M_______F Phone: ________________________
Primary Care Physician/Pediatrician: ____________________________________

Current medications and dosage:______________________________________

Statement of the Problem:
Describe speech/communication/executive function
problem(s):____
____
____

When was the problem first noticed (month/year)?________________________
What do you think caused your/your child's problem?_____________________
____

Has the problem: stayed the same/worsened/improved since first noticed?
(circle one)

How would you rate the severity of the problem?
________Mild__________Moderate________Severe

List the difficulties that the problem causes you/your child in terms of interactions, academics, home life, socializations, teasing, communicating, etc.
____
____
____

Previous evaluations or treatments related to this problem:
____Medical____Psychological____Neurological____Speech Therapy
____Neuropsychology____Surgical____Other (Early Intervention, PT, OT)

Client:_____________________

Describe: (Please give name of professional, approx. dates, brief results or summary):____
____

MEDICAL STATUS:_____Excellent____Good_____Fair_____Poor

Check all that apply (past and present):

___Head injury
___Family history of speech problems
___Stroke
___Bronchitis
___Pneumonia
___Heart Disease
___Aspiration/Choking/Coughing
___Seizures
___Allergies
___Ear Infections/Ear tubes
___Frequent laryngitis
___Asthma
___Emphysema
___Diabetes
___Thyroid Disorder
___Cancer
___High blood pressure
___Substance Abuse
___Smoking
___Alcohol
___Sinus Problems
___Frequent Sore Throats
___Major accidents, illnesses, surgeries, or hospitalizations (please describe and include approx dates):____
____
___Other (please describe):____
____

HEARING:

Newborn Hearing Screening: ___Pass___Fail___N/A
Previous School/Pediatrician Hearing Screening: ___Pass___Fail___N/A
Previous Hearing Evaluation: ___Pass___Fail___N/A
Central Auditory Processing (CAP) Evaluation___Pass___Problem Areas:
____

Describe: (Please specify approximate date, professional/name of practice, and results)____
____
____

INFORMATION PERTAINING TO PATIENT:

Highest level of education:_____________
If you are a student are you going full time or part time?____________________
Academic difficulties (if so, please describe):_____________________________
____
____
School Service Plan:___Individualized Education Plan (IEP)___504 Plan

Client:____________________

Occupation:_____________________Employed Full Time or Part Time?______
Marital Status:___Single___Married___Widowed___Divorced
Living with:____
Ages of Children:___________________

FAMILY HISTORY:

Is there a family history of speech and language difficulties (parents, grandparents, aunts, uncles, cousins, etc.)? If so, please list relationship to patient, type of problem, if speech therapy was provided, and if so for how long:
____
____
____
____

PRENATAL/BIRTH HISTORY:

Please check all that apply:
_____Premature (# of weeks premature: __________)
_____NICU (length of stay: ___________)
_____Low birth weight (_____lbs_____oz)
_____Complications with pregnancy or birth (please describe)_______________
____
____

DEVELOPMENTAL HISTORY:

Please give ages for the following developmental milestones:
_____Sat alone
_____Crawled
_____Stood alone
_____Walked alone
_____First words
_____Combined 2-3 words
_____Spoke in sentences

Please check the following, if they apply:
_____Hyperactivity
_____Attention problems
_____Overactive/Easily Distracted
_____Difficulty socializing with peers
_____Behavioral issues
_____Other areas of concern:____

Client:________________________________

EXECUTIVE FUNCTIONS:
(Please complete if this is a problem area)

Please describe your overall concerns in this area:

____
____
____

Describe how you/your child functions in the following areas:

Time Management:

____
____
____

Planning/Organization:

____
____
____

Managing Emotions:

____
____
____

Memory:

____
____
____

Impulse Control:

____
____
____

Attention to Task:

____
____
____

Client:_________________________

FEEDING/SWALLOWING:

(Please complete if this is a problem area)

Please describe you/your child's feeding/swallowing history:

Breast fed___yes___no
Bottle fed___yes___no

Liquids:
At what age did your child:
Drink from a cup:______
Straw:__________
Does your child cough/choke when drinking liquids? ______yes _____no
If yes, please describe:

____
____
____

Solids:
At what age did your child:
Start puree foods by spoon:_______
Finger foods:________
Chewable foods (e.g., meats, Cheerios, pasta, etc)
Does your child cough/choke/gag/pocket foods in cheeks?____yes ____no
If yes, please describe:

____
____
____

Does your child avoid certain types of food/textures?___yes___no
If yes, please describe:

____
____
____

Please provide any additional information that you feel is relevant to your child's feeding/swallowing history:

____
____
____