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Confidential Case History Questionnaire

Today's Date:
Child's Name: Date of Birth:
Address:
City: State: Zip:
Parent's Name:
Home Phone: Cell Phone: Business Phone:
Email Address:
Child lives with: (circle) both parents father mother other
Person to contact in an emergency:
Physician/Pediatrician: Phone:
Medical Diagnosis:
Other Physicians/Specialists/Professionals working with your child:
Name: Phone:
Name: Phone:
Name: Phone:
Insurance Information: Please submit a copy of the front and back of insurance card.
Insurance Company:
Person Insured: Date of Birth:
Insurance Address:
Insurance Phone number:
Group Number: Policy Number:
Referral Information:
Referred By:
Describe your concerns and goal for your child.
Has your child received any interventions or services up to this date? If yes please explain:

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Child's Birth History and Development:
Prenatal:
Is your child adopted? If so, at what age?
Did mother have any infections, illnesses, injuries or other complications during pregnancy? If yes, please explain.
Please list any medications taken during pregnancy or delivery:
Birth and Infancy:
Location of Birth: Birth Weight:
Was pregnancy full term?
Was labor (circle ones that apply) normal short prolonged induced
Was delivery(circle ones that apply) normal breech caesarean forceps used
Was child incubated? If yes, how long?
Were there any other complications at birth? Jaundice transfusions
Breathing difficulty feeding difficulty apgar score
Other:
Describe any congenital defects:
As an infant did your child seem: (circle all that apply) happy cried frequently
Sleep long hours wake often feed slowly eat well liked being rocked
Fuss when held colicky difficult to soothe difficult to get to sleep
Difficult to hold/cuddled
Motor Development:
At what age did your child do the following? **Age**
Roll over
Crawl
Walk
Sit alone
Drink from a cup
Chew solid food
Eat with utensils
Tie shoe laces
Was the crawling phase prolonged, brief or almost entirely eliminated?
Can your child do the following? If yes, indicate the quality of child's performance:
No Yes 1=Poor 2=Average 3=Good
Hop on one foot
Skip with both feet
Climb on and over objects
Jump with both feet together
Ride a tricycle
Ride a bicycle (with/without training wheels)

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Motor Development continued:					
	No	**Yes**	**1=Poor**	**2=Average**	**3=Good**
Jump rope					
Roller-skate					
Kick a ball					
Pump self on swing					
Cut with scissors					
Color inside lines					
Play with puzzles and manipulative toys					
Have consistent hand dominance					
Blow soap bubbles					
Blow whistles					
Suck through a straw					
Medical History					
Has your child had any history of the following? If yes please explain and give dates.					
Child hood diseases or major illnesses?					
Surgery?					
Serious Injury?					
Cast or braces?					
Allergies?					
Frequent ear infections?					
Dietary restrictions?					
Is your child currently taken any medications? If yes please list medications by name and state what condition the medication is treating?					
Has your child ever had a psychological, developmental, neurological, psychiatric, or EEG/MRI evaluation? If so why and what were the results?					

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Speech and Language Developmental History:
What age did your child do the following? **Age**
Say single words?
Put 2-3 words together in a phrase?
What were his/her first words?
How many words does your child currently use? Circle one
0-5 10-20 20-50 50-100 >100
What is your child's primary way to make his/her wants and needs known?
Is your child difficult to understand at times?
Are there any languages spoken in the home other than English? If so, what?
Fluency
Does your child stutter or stammer?
How long have you observed dysfluencies?
Is your child aware/concerned/frustrated?
Voice
Does your child's voice exhibit any of the following qualities? Circle all that apply
Hoarse harsh nasal very soft very loud other
Feeding
Have there been any feeding problems?
Any problems with sucking, chewing, choking, or swallowing?
Are the child's food preferences a concern?
Have there been any problems with liquids?
What are some of the foods that are typical in child's diet?
Social Development and Play Skills
Describe your child's personality:
Describe any social problems your child has with friends and family:
What are his/her favorite activities/toys/games?
Does your child play appropriately with these toys?
How long does he/she play with one toy?

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Social Development and Play Skills
Whom does the child prefer to play with?
What makes the child smile and laugh?
What play activities does the child least enjoy?
How does the child play when left alone?
What does child do when angry or frustrated?
Does your child tend to play with things by lining them or piling them up?
Please describe any other concerns you may have regarding your child's social skills or play skills?
Activities of Daily Living
What self help skills does your have? Please tell us if they are: unable, independent, needs assistance, needs supervision only.
Dresses self
Undresses self
Toilets self
Brushes teeth
Washes hands
Feeds self
Drinks from cup
Zips zippers
Buttons
Snaps & hooks
Puts on shoes
Laces shoes
Ties shoes
Sensory History
Has your child had a hearing exam? Yes No Date of test:
Who performed the test? Result of test:
Has your child had an eye exam? Yes No Date of test:
Who performed the test?
Does your child wear glasses:

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Are there sounds that your child particularly likes or dislikes?
Are there textures that your child likes or dislikes?
What food does your child particularly dislike?
What odors does your child particularly like or dislikes?
Please review the sensory list below and indicate the number that best describes your child:

	1=Never	**2=Seldom**	**3=Sometimes**	**4=Often**	**5=Always**
Responds negatively to loud noise?					
Missed hearing some sounds?					
Unable to follow 2 or 3 directions given at once?					
Has difficulty paying attention when there is loud noise present?					
Likes to sing or dance to music?					
Has difficulty copying rhythms?					
Has difficulty remembering what he /she said?					
Has speech or articulation problems?					
Avoid hard or crunchy food textures?					
Keep an open mouth posture at rest?					
Suck his/her thumb or fingers?					
Puts toys/objects in his/hers mouth?					
Avoids putting hands in messy substances?					
Dislikes being touched unexpectedly?					
Tends to feel pain when hurt?					
Show sensitivity to clothes or tags?					
Prefer to touch than to be touched?					
Pinch, bites or otherwise hurts self?					
Bangs head on purpose, now or in past?					
Avoids using hands for extended periods?					
Blinks at bright lights?					
Reverse letters or numbers?					
Likes to be in the dark?					
Has difficulty with eye contact?					
Rocks in bed, now or in past?					
Spins or whirls more than most children?					
Jumps a lot?					
Seems fearful of space?					
Gets car sick?					
Likes fast movement?					
Has trouble learning to climb stairs?					
Walks on toes, now or in past?					

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Please review the sensory list below and indicate the number that best describes your child:					
	1=Never	**2=Seldom**	**3=Sometimes**	**4=Often**	**5=Always**
Appears clumsy or falls often?					
Has poor motor coordination with small things?					
Has an awkward grasp with a pencil?					
Appears to have normal sense of taste?					
Appears to have normal sense of smell?					
Tends to explore orally or with smell?					
Has trouble learning urinary control?					
Has trouble learning bowel control?					
Has trouble with bed wetting?					
Seem sensitive to criticism?					
Hesitates to try new task?					
Has definite fears?					
Has temper tantrums?					
Displays affection for others?					
Difficulty falling asleep or stay asleep?					
Impulsivity or hyperactivity?					
Unusually distractible?					
Are there any specific questions you would like to address about your child?					
What would you like for your child to achieve?					

I understand that I am responsible for payment in full at the time of evaluation/therapy. Unless other arrangements have been made in advance and approved by the clinical director at Frankly Speaking SLP, Inc.

Please print name: _____

Signature: _____

Relationship to child: _____ **Date:** _____