Watson Speech and Language Services

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508-237-6643

Pediatric Case History Form

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(e-mail used only for communication from this office and for billing/receipts)

Home Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Information provided in this history is confidential, and is used to help with the

assessment of your child. This information will not be provided to other agencies

without your written consent.

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Family History:

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Speech, Language, or Learning problems? \_\_\_\_ YES \_\_\_\_ NO

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Speech, Language, or Learning problems? \_\_\_\_ YES \_\_\_\_ NO

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Siblings—Names & Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who currently lives in the home with your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a family history (parents, siblings, aunts, uncles, cousins, grandparents) of

any of the following?

Family Member Family Member

Hearing Loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcoholism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Learning Disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seizure Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reading Difficulty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech Difficulty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drug Abuse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is English the primary language spoken in the home? \_\_\_\_ YES \_\_\_\_ NO

If NO, what is the primary language spoken in the home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prenatal & Birth Complications: Check any items that apply regarding the birth of your

child:

During pregnancy:

\_\_\_\_ Excessive vomiting \_\_\_\_ RH Incompatibility \_\_\_\_ Significant Illness

\_\_\_\_ Drug Use \_\_\_\_ Alcohol Use \_\_\_\_ Smoking

\_\_\_\_ Previous Miscarriages \_\_\_\_ Trauma/Injuries \_\_\_\_ High Blood Pressure

Additional information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Labor & Delivery:

\_\_\_\_ Full Term \_\_\_\_ Premature: \_\_\_\_ weeks early \_\_\_\_\_\_ Birth Weight

\_\_\_\_ Normal Delivery \_\_\_\_ Forceps Delivery \_\_\_\_\_\_ Cesarean

Complications After Birth:

\_\_\_\_ Difficulty Breathing \_\_\_\_ Difficulty Sucking \_\_\_\_ Difficulty Feeding

\_\_\_\_ Seizures \_\_\_\_ Jaundice \_\_\_\_ HIV \_\_\_\_ Sepsis

\_\_\_\_ Extended Hospital Stay—How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain any items above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History: Has your child had any of the following?

\_\_\_\_ Chicken Pox \_\_\_\_ Encephalitis \_\_\_\_ Asphyxia (Oxygen/Breathing Loss)

\_\_\_\_ Meningitis \_\_\_\_ Asthma \_\_\_\_ Allergies

\_\_\_\_ Head Injury \_\_\_\_ Seizures \_\_\_\_ Tonsils/Adenoids Removed

\_\_\_\_ Multiple Ear Infections \_\_\_\_ Tubes Inserted? Which ear? \_\_\_\_\_\_\_\_

Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List medications your child currently takes, dosage, and why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other diagnoses your child has been found to have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RETURN TO

**Hearing History:**

Do you suspect that your child has a hearing loss? \_\_\_\_\_\_\_\_

If YES, what behaviors does your child display that lead you to suspect hearing loss?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child’s hearing been tested? \_\_\_\_ YES \_\_\_\_ NO

Where and When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results of Testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child use Hearing Aids? \_\_\_\_ YES \_\_\_\_ NO

If so, which ears? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech/Language Development: What age did your child demonstrate the following

(estimate):

\_\_\_\_\_\_\_ Cooing, pleasure sounds \_\_\_\_\_\_\_\_ Babbling (ba-ba, da-da)

\_\_\_\_\_\_\_ Jargon (talking in own special language) \_\_\_\_\_\_\_\_ Single words

\_\_\_\_\_\_\_ Phrases (go bye-bye, more juice) \_\_\_\_\_\_\_\_ Short sentences

How does your child let you know what he/she wants? Please check all that apply.

\_\_\_\_\_ Looking at Objects \_\_\_\_\_ Pointing at Objects \_\_\_\_\_ Gestures

\_\_\_\_\_ Crying \_\_\_\_\_ Making sounds \_\_\_\_\_ Touch/Grab

\_\_\_\_\_ Single Words \_\_\_\_\_ 2–3 Words \_\_\_\_\_ Sentences

Describe your child’s speech:

\_\_\_\_\_ Easy to understand

\_\_\_\_\_ Easy for family members to understand, difficult for others

\_\_\_\_\_ Difficult for family members to understand and also difficult for others to

understand

Does your child have difficulty pronouncing certain kinds of words?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child get “stuck” or “stutter” when speaking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have concerns about your child’s voice? (hoarse, breathy, too soft, very loud)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RETURN TO

Motor Development: What age did your child demonstrate the following (estimate)?

\_\_\_\_\_\_\_\_ Sitting Up \_\_\_\_\_\_\_\_ Crawling \_\_\_\_\_\_\_\_ Standing

\_\_\_\_\_\_\_\_ Walking \_\_\_\_\_\_\_\_ Finger feeding \_\_\_\_\_\_\_\_ Eating with spoon

\_\_\_\_\_\_\_\_ Potty-trained \_\_\_\_\_\_\_\_ Undressing self

Has your child had any feeding difficulties?

\_\_\_\_\_ Sucking or Nursing \_\_\_\_\_ Excessive length of time to drink a bottle

\_\_\_\_\_ Regurgitation of liquids or solids through nose \_\_\_ Difficulty chewing/swallowing

\_\_\_\_\_ Choking and/or gagging

Did your child drool more than other children his/her age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child have difficulty gaining weight as an infant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social/Emotional Development: Check behaviors that describe your child:

\_\_\_\_ Overly quiet \_\_\_\_ Overly active \_\_\_\_ Excessive tantrums

\_\_\_\_ Destructive \_\_\_\_ Friendly, outgoing \_\_\_\_ Plays well with other children

\_\_\_\_ Prefers older kids \_\_\_\_ Prefers younger kids \_\_\_\_ Defiant

\_\_\_\_ Right handed \_\_\_\_ Left handed \_\_\_\_ Trouble sleeping

\_\_\_\_ Plays poorly with other children \_\_\_\_ Prefers to play by himself

Check all of the types of play your child likes to do most often:

\_\_\_\_ Putting toys in mouth \_\_\_\_ Banging toys together \_\_\_\_ Throwing toys

\_\_\_\_ Pushing/pulling toys \_\_\_\_ Uses toys appropriately \_\_\_\_ Role-playing games

\_\_\_\_ Make Believe play \_\_\_\_ Plays games with rules \_\_\_\_ Rough and tumble play

Describe any evaluations or therapy for behavioral or emotional difficulties:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Educational History:

Educational Setting School Name and Approximate Dates

Preschool:

Elementary School: Grades \_\_\_\_\_

Middle School: Grades \_\_\_\_\_

High School: Grades \_\_\_\_\_TOC

How many days per week does your child attend school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been retained? If so, which grade? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have difficulty with: \_\_\_\_ Reading \_\_\_\_ Math \_\_\_\_ Writing

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any accommodations made for your child at school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any special education services or IEP services your child receives at school:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been evaluated or attended therapy for:

\_\_\_\_ Speech Therapy \_\_\_\_ Language Therapy

\_\_\_\_ Reading difficulty \_\_\_\_ Math difficulty \_\_\_\_\_ Writing Difficulty

\_\_\_\_ Occupational therapy \_\_\_\_ Physical therapy

Please give locations and dates for above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_