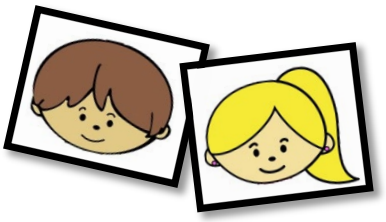
Confident Kids Speech Therapy

New Patient Case History Form



Identifying and Family Information:

Child's Name:_____ Birthdate:_____ Sex: ❑M ❑F

Caregiver 1: _____ Birthdate:_____

Address:_____ Cell Phone:_____

_____ E-mail:_____

_____

Caregiver 2: _____ Birthdate:_____

Address:_____ Cell Phone:_____

_____ E-mail:_____

_____

Doctor's Name: _____ Doctor's Phone: _____

Child lives with (check one):

❑Birth Parents ❑Foster Parents ❑One Parent

❑Adoptive Parents ❑Parent and Step-Parent ❑Other _____

Other children in the home:

Name	Age	Sex	Grade	Speech/Hearing Problems

Is there a language other than English spoken in the home? ❑Yes ❑No

If yes, which one?_____

Does the child speak the language? ❑Yes ❑No

Does the child understand the language? ❑Yes ❑No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

Speech-Language-Hearing

Please describe the concerns you have with your child's speech and any personal goals that you have for your child's communication._____

_____

_____

Has he/she ever had a speech evaluation/screening? ❑Yes ❑No

If yes, where and when? _____

What were the results? _____

_____

_____

Has your child ever had speech therapy? ❑Yes ❑No

If yes, where and when? _____

What was he/she working on? _____

_____

Do you feel your child has a hearing problem? ❑Yes ❑No

If yes, please describe. _____

_____

_____

Has he/she ever had a hearing evaluation/screening? ❑Yes ❑No

If yes, where and when? _____

What were you told? _____

_____

_____

Has your child received any other evaluation or therapy (physical therapy, occupational therapy, autism, play therapy, behavior therapy, etc.)? ❑Yes ❑No

If yes, please describe._____

_____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties?_____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What motivates your child (stickers, hugs, praise, bubbles, toys, food, etc.)?_____

_____

Birth History

Was there anything unusual about the pregnancy or birth? ❑Yes ❑No

If yes, please describe. _____

_____

_____

Did you carry the pregnancy full term or was the child born prematurely?_____

Was extra hospitalization required? ❑Yes ❑No

If yes, please describe why and how long. _____

_____

_____

Medical History

Has your child had any of the following?

- ❑adenoidectomy
- ❑allergies
- ❑breathing difficulties
- ❑chromosomal anomaly
- ❑ear infections
  How often?_____
- ❑ear tubes
- ❑head injury
- ❑seizures
- ❑sinusitis
- ❑sleeping difficulties
- ❑tonsillectomy
- ❑tonsillitis
- ❑vision problems

Does your child have any other medical or developmental diagnosis: _____

Other serious injury/surgery that may impact speech development: _____

Is your child currently (or recently) under a specialist's care? ❑Yes ❑No

If yes, why?_____

_____

Please list any medications your child takes regularly: _____

_____

_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone
_____ crawled
_____ put two words together
_____ walked
_____ self fed
_____ said first words
_____ spoke in short sentences
_____ engaged in conversation

Does your child...

- ❑ have any feeding/swallowing issues?
- ❑ have any food aversions?
- ❑ prefer certain colors, textures, etc.?
- ❑ have any oral motor issues?
- ❑ have any tongue or lip tie issues?
- ❑ have any dental problems/teeth issues?

Current Speech-Language-Hearing

Type of Exam Requested:
LANGUAGE: are you concerned with…

- ❑ the number of words your child is using
- ❑ your child's ability to understand what you are saying?
- ❑ your child's ability to combine words or phrases?
- ❑ vocabulary skills?
- ❑ grammar skills?

STUTTERING:

- ❑ are you concerned with stuttering?

ARTICULATION: are you concerned with…

- ❑ the pronunciation or articulation or words?
- ❑ specific sounds?
- ❑ does your child have a lisp?

Do you have any additional concerns: _____

_____

_____

SCHOOL HISTORY

If your child is in school, please answer the following:

Name of school and grade: _____

_____

Do they attend full time/part time or other: _____

_____

Do teachers express concern with communication skills? _____

_____

What are your child's strengths and/or best subjects? _____

_____

What do you see as your child's most difficult problem in school? _____

_____

Is your child receiving support/accommodations? _____

_____

SCHEDULING

Please be as specific as possible to avoid any delays in getting started:

What days/times work best for therapy? (please circle)

Mondays	Tuesdays	Wednesdays	Thursdays	Fridays
Early Mornings 8:30 – 10:00	Mid Mornings/Noon 10:30 – 12:30	Early Afternoons 1:00 – 3:00	Afterschool 3:30 – 5:00	Early Evenings after 5:30

Are there any days/times that **do not** work for your schedule? (please circle)

Mondays	Tuesdays	Wednesdays	Thursdays	Fridays
Early Mornings 8:30 – 10:00	Mid Mornings/Noon 10:30 – 12:30	Early Afternoons 1:00 – 3:00	Afterschool 3:30 – 5:00	Early Evenings after 5:30

Therapy Location:
If your preferred place of therapy is different from our office, please provide the address requested:

_____

PLEASE NOTE: Mobile therapy is not always available due to availability, location, timing and other factors however we will try our best to accommodate your request.

Additional Comments

www.confidentkidsspeechtherapy.com
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