Speech • Language • OT • PT

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CASE HISTORY

GENERAL INFORMATION

Client's name:		Birthdate:		Age:		Gender:	
Address:		City, State, Zip:					
Mother's name:		Email:		Phone:			
Father's name:		Email:		Phone:			
Emergency contact:		Relationship:		Phone:			
Physician:		Name of clinic:		Phone:			
Dentist:		Name of clinic:		Phone:			
Orthodontist:		Name of clinic:		Phone:			
Client's strengths:							
Concerns that prompted you to contact us:							
What services are you seeking from our clinic?							
How did you hear about Communication Works?							

PERSONAL HISTORY

Client currently lives with:		Primary language spoken in the home:						
Stressful situations client has experienced within the last year:								
Please identify family members (e.g., mother, grandfather, brother, daughter) that have a history of:								
Speech challenges:		Tongue tie or thrust:		ADHD:				
Reading, writing or other learning challenges:		Autism:						
Cognitive disability:		Mental illness:		Hearing loss:				
Amount of time client spends with technology each day:	Gaming:		TV:		YouTube:		Texting:	

PREGNANCY/BIRTH HISTORY

Length of pregnancy in weeks:		Mother's age at delivery:		Birth weight:	
Complications during pregnancy or at birth:					
Type of birth:		Breathing complications at birth:			
If baby was not discharged with mom, describe why:					

FEEDING HISTORY

Breast fed:		Duration of breast feeding:		Complications:	
Bottle fed:		Duration of bottle feeding:		Complications:	
Did baby make clicking or smacking noises while nursing or bottle feeding?					
Did milk dribble out of the mouth while nursing or bottle feeding?					
Difficulty transitioning from breast/bottle to purees? If yes, describe:					
Difficulty transitioning from purees to solid food? If yes, describe:					
Difficulty swallowing liquids, purees, or solids? If yes, describe:					
Choking or gagging while eating? If yes, describe:					
Chews food slowly? With effort? Too fast? Not thoroughly? Just right?					
Chews with mouth open?		Is client a noisy eater?			
Takes bites that are too small? Too large? Just right?					

Shows frustration when eating? If yes, describe:	
History of spitting up or reflux after eating? If yes, describe:	
Picky eater? If yes, name foods client avoids:	
Foods client prefers:	
Diet restrictions or food allergies:	

SUCKING HABITS

Has client ever sucked thumb or fingers? If so, which thumb/fingers?		Age stopped:	
Did client use a pacifier?		Age stopped:	
Have you ever tried to stop the sucking habit? If so, what strategies were tried?			
If it is ongoing would you like to eliminate the sucking habit?			

DEVELOPMENTAL HISTORY

When did child:

Roll over:		Sit alone:		Crawl:		Walk:		Jump:	
Hop on 1 foot:		Ride a bike:		Eat with a spoon:		Scribble:			
Write name:		Show hand preference:		Which hand?					
Toilet trained during the day:		Toilet trained during the night:							

Does child:

Take off/put on pants	Independently, half the time, or not at all:	
Take off/put on shirt	Independently, half the time, or not at all:	
Take off/put on socks	Independently, half the time, or not at all:	
Take off/put on shoes	Independently, half the time, or not at all:	
Tie shoes	Independently, half the time, or not at all:	
Button	Independently, half the time, or not at all:	
Zip	Independently, half the time, or not at all:	
Snap	Independently, half the time, or not at all:	
Drink from cup	Independently, half the time, or not at all:	
Brush teeth	Independently, half the time, or not at all:	
Toilet alone	Independently, half the time, or not at all:	

MEDICAL HISTORY

General

Syndromes (e.g., Down, Turner):	
Serious illnesses, surgery, or bodily injuries:	
Chronic conditions (e.g., seizures, physical disabilities):	
Hearing/vision problems:	
ADHD:	
Self-injurious behavior:	
Medications:	

Head

Head injury/concussion	If yes, cause & severity:	
Headaches	If yes, frequency/severity:	
Migraines	If yes, frequency/severity:	

Ears/Nose/Throat

Ear infections	None, Some, Frequent:	
PE tubes	If yes, date and outcome:	
Post nasal drip	None, Some, Frequent:	
Congestion/colds	None, Some, Frequent:	
Nasal polyps	None, Some, Frequent:	
Strep throat	None, Some, Frequent:	

Tonsillitis	None, Some, Frequent:	
Tonsillectomy	If yes, date and outcome:	
Adenoidectomy	If yes, date and outcome:	
Dental/Mouth		
Cavities	None, Some, Many:	
Gum disease	None, Some, Frequent:	
Mouth sores	None, Some, Frequent:	
Teeth crowding	If yes, resulting issues:	
Teeth extractions	If yes, date and outcome:	
Narrow palate	Yes, No	
Palatal expander	If yes, date and outcome:	
Braces	If yes, date and outcome:	
Dental appliance	If yes, date and outcome:	
Tongue-tie release	If yes, date and outcome:	
Jaw/TMJ problems	If yes, frequency/severity:	
Strong gag reflex	If yes, describe:	
Gastrointestinal		
Indigestion	If yes, frequency/severity:	
Heartburn	If yes, frequency/severity:	
Bloating	If yes, frequency/severity:	
Belching/flatulence	If yes, frequency/severity:	
Constipation	If yes, frequency/severity:	
Vomiting	If yes, frequency/severity:	
Respiratory/Breathing		
Asthma	If yes, frequency/severity:	
Bronchitis	If yes, frequency/severity:	
Heavy/noisy breathing	If yes, frequency/severity:	
Smoke exposure	If yes, frequency/severity:	
Mold exposure	If yes, severity:	
Pet in the home	If yes, allergic reaction?	
Environmental allergies	If yes, type & severity:	
Sleeping		
Snoring/heavy breathing	If yes, frequency/severity:	
Sleep apnea	If yes, frequency/severity:	
Teeth grinding	If yes, frequency/severity:	
Open mouth	If yes, frequency/severity:	
Drooling	If yes, frequency/severity:	
Restless sleep	If yes, frequency/severity:	
Nightmares	If yes, frequency/severity:	
Bedwetting	If yes, frequency/severity:	
Difficulty waking up	If yes, frequency/severity:	
Wakes w/headaches	If yes, frequency/severity:	
Daytime sleepiness	If yes, frequency/severity:	

COMMUNICATION/ACADEMIC/SOCIAL HISTORY (please identify any of the following challenges):

Speech sound errors interfere with ability to be understood	
Sounds like s/he is stuttering	
Repeats what others say, but with no apparent meaning	
Perseverates on ideas or preferred topics	
Difficulty sequencing/organizing ideas to relate a story or event	
Difficulty following directions or conversations	

Difficulty starting or maintaining a conversation	
Difficulty learning new things	
Difficulty sounding out words	
Difficulty memorizing sight words	
Difficulty with reading comprehension	
Difficulty with writing skills	
Increased effort/time required to complete homework	
Attitude toward school and learning	
Difficulty attending/maintaining focus	
Distractible/impulsive	
Unorganized/lack of planning/difficulty completing tasks	
Easily frustrated	
Disobedient/defiant/uncooperative/resistant	
Aggressive toward people (e.g., hits, pushes, kicks)	
Destructive toward property (e.g., breaks items on purpose)	
Has difficulty telling the truth	
Makes poor choices at home and/or school	
Fearless OR overconfident	
Indecisive/fearful/anxious	
Unusual body movements (e.g., spins, rocks, flaps hands)	
Avoids eye contact/tends to ignore others	
Teased or not accepted by others	
Has difficulty making/keeping friends	
Comments:	

SCHOOL/OTHER SERVICES

Current school:		Grade:		Classroom/homeroom	
Extra-curricular activities:				Musical instrument:	
Does your child have an established IEP?		504 Plan?		Verification:	

Type of Service	Agency	Name of Provider	Times/week or month	Age or date service began	Age or date service ended
Speech therapy					
Occupational therapy					
Physical therapy					
Resource					
SAP/MTSS					
Psychologist					
After school care					
Preschool/day care					
Other					

NAME OF PERSON COMPLETING CASE HISTORY **RELATIONSHIP TO CLIENT** **DATE**

Please provide the most recent reports from the above agencies so we may plan appropriate services. Thank you!
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