Date: ____/____/____

Speech, Language, and Feeding Case History

[Please fill out the following form to the best of your knowledge. By providing Community Therapy Services with this information you are giving our therapists a chance to know your child and their needs better. This in turn allows us to provide them with the best possible care. You may omit any information that does not apply. Thank you for your time.]

Child's Name: ________________________ Date of Birth: ____ / ____ /____

REASON FOR ASSESSMENT: ____
____
____
____

HEALTH HISTORY: Please list problem with age of occurrence.

Present diagnosis: ____
____

Food allergies or intolerances:____
____

Surgeries: ____
____

Hospitalizations: ____
____

Medication(s): ____
____

Medical Conditions:

☐ Reflux	☐ Sleeping difficulties	☐ Head injury
☐ Ear infections	☐ Frequent respiratory infections	☐ Torticollis
☐ Seizures	☐ Cardiac issues	☐ GI issues
☐ Vision problems	☐ Tonsillectomy	☐ Breathing difficulties
☐ Vocal cord dysfunction	☐ Adenoidectomy	☐ Allergies (environmental)
☐ Other		

Pregnancy:
Full term: ☐ Premature: ☐ If yes, how many weeks_______ Due date:_______________
Birth:
Vaginal: ☐ C-Section: ☐ Birth weight: ___________ Current weight: _____________

Please describe any other pregnancy/birth complications: ________________________________
____
____

Current/Past Therapies:

Therapies	**Date**	**Location**
☐Speech Therapy		
☐Physical Therapy		
☐Occupational Therapy		
☐Early Intervention		

HEARING HISTORY:

Has your child ever had a hearing test? _________ If so, when (date) _______________
What were the results? ____
____

Any history of ear infections? ____

Does your child seem irritated and / or unusually sensitive to noise? ________________
If so, explain: ____
____

VISION HISTORY

Has the child ever had a vision test? _______ If so, when (date) ___________________
What were the results? ____
____

If vision is corrected with glasses, how successful is the correction? _________________
____

SCHOOL HISTORY

Child's school or preschool:____

Grade or program____

Does your child receive any special services at school? Please list:
____
____

SENSORY HISTORY

Does your child: Please circle "yes", "no", or "unsure".

Tactile Sensation

Object to certain clothing or kinds of touch?	yes	no	unsure

Comments: ______________________________

____

____

Auditory Sensation

Seem overly sensitive to some sounds (ex. loud or unexpected)	yes	no	unsure

Comments: ______________________________

____

____

Visual Sensation

Sensitive to bright lights?	yes	no	unsure
Become excited when confronted with variety of visual stimuli?	yes	no	unsure

Comments: ______________________________

____

____

Vestibular Sensation

Avoid or seem fearful of movement (i.e. going up and down stairs, riding teeter-totter)?	yes	no	unsure
Appear clumsy, often bump into things or fall down?	yes	no	unsure
Crave movement like spinning or swinging?	yes	no	unsure

Comments: ______________________________

____

____

Muscle Tone

Have a weak grasp?	yes	no	unsure
Tire easily with physical activity?	yes	no	unsure
Tire easily when eating?	yes	no	unsure

Comments: ______________________________

____

____

Relaxation, Integration and Development

Was your child slow to reach the usual developmental milestones? yes no unsure

Was your child irritable in infancy, particularly when held? yes no unsure

Does your child seem overwhelmed in new situations? yes no unsure

Is your child's play repetitive or lack variety? yes no unsure

Does your child seem stressed or confused at changes in the routine?

Comments: ____

____

____

SPEECH / LANGUAGE / SOCIAL HISTORY:

What language(s) is spoken in the home? ______________________________________

Was your child generally a: quiet baby _______ average noisy baby _______ very noisy baby _______

When did your child first babble? ____

When did your child say his / her first words? _________________________________

What were your child's first words / phrases? _________________________________

____

Check any of the items below that apply to your child:

Child does not speak clearly _______
Child does not follow directions _______
Child has trouble paying attention for a long period of time _______
Child has trouble understanding _______
Child has trouble remembering _______
Child has trouble expressing self _______
Child has trouble relating to others _______
Child has trouble playing with other children _______

What are your child's favorite toys or play objects? _____________________________

____

____

List your child's best qualities: ____

____

____

Please list any regular school or social activities your child participates in:

____
____

Has your child ever received therapy? If so, explain type, location, and results:

____
____
____
____

Additional concerns or questions regarding communication: _________________________

____
____
____

PHYSICAL DEVELOPMENT HISTORY:

Do you have any concerns about physical development? yes _______ no _______
At what age did your child:

Sit up ________ Crawl ________
Stand ________ Walk ________

FEEDING HISTORY:

[If you have no feeding concerns, you may skip this section.]

Has your child ever had a feeding evaluation and/or videoflouroscopic swallow study? When, where, and what were the results?

____
____

Taste preferences?

☐Salty ☐Sweet ☐Spicy ☐Tart ☐Flavored ☐Bland

Comments:

____

Texture preferences?

☐Crunchy ☐Crisp ☐Smooth ☐Lumpy ☐Uniform lumpy (cottage cheese)

☐Hard ☐Chewy ☐Mixed consistencies

Comments:

____

Temperature preferences?

☐Hot ☐Warm ☐Cold ☐ Cool

Comments:

____

Please list your child's favorite foods/liquids:
____
____

Please list your child's least favorite foods/liquids: ______________________________
____
____

What foods would you like to see your child eat? ______________________________
____
____

What does your child use to drink liquids?
Bottle ______ Sipper Cup ______ Straw ______ Cup ______
Other ____

Does your child feed himself? ______ Finger foods _______ Uses utensils _______

Does your child drool? ______ How much? ______________________________

Where is your child fed (e.g. in a chair, lap)? __________________________________

Who usually feeds your child? ____

How is your child's appetite? _______Good ________Poor ________Inconsistent
Best time of day to eat _____________________
Comments:

Does your child gag or vomit? _______ During mealtimes ______ After mealtimes (at least 30 minutes) How often: _____________________
Comments:

Do you have any concerns regarding your child not addressed above?

____________________________________ ______ / ______ / _____

Signature of Parent / Guardian Date