Stony Brook Medicine

Pediatric Speech - Language Pathology Case History

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Name: _____ Date of birth: _____
Mother's Name:_____ Father's Name:_____
Address:_____
Telephone: (home) _____(work) _____(cell) _____ _____
Reason for evaluation:_____
Insurance: _____ Policy Number: _____Referral Needed: □yes □no
Referred by _____
Person completing form □ Patient □ Spouse □ Parent/Guardian □ Other- Name_____
Results will be sent to names/locations listed below if address or faxes are provided
Name Address or Fax Phone
_____
_____
_____

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers.

_____Name
Relationship to patient Address phone fax
_____Name
Relationship to patient Address phone fax

I authorize the Department to disclose healthcare information to names above. Valid for one year.
Signature of □ Patient □ Parent/Guardian _____ Date _____ Printed Name of Parent/Guardian _____

Pregnancy History:

Length of pregnancy: _____weeks
Please describe any illness/hospitalization of mother during pregnancy:_____
_____
Parent drug use before pregnancy: □ YES □ NO If yes, please explain:_____
Alcoholic intake during pregnancy □ YES □ NO If yes, list # per week:_____
Mother drug use during pregnancy □ YES □ NO If yes, please explain:_____
Mother prescription drug use during pregnancy? □ YES □ NO If yes, please explain:_____

Birth History:

Hospital Name/Location: _____
Delivery: □ Vaginal delivery □Caesarean delivery; Why?_____
Was the child one of a multiple birth?_____ Birth Weight:_____
Was anesthesia/medication given? □ YES □ NO If yes, what kind?_____

Complications / Treatments:		How Long
Cord around neck?	□ YES □NO	_____
Breathing Problems?	□YES □NO	_____
Transfusions?	□YES □NO	_____
Phototherapy?	□YES □NO	_____
Respirator Use?	□YES □NO	_____
Incubator Use?	□YES □NO	_____

Other:_____
Did the baby go home with the mother? □YES □NO How long after?_____

Pediatric SLP Case History page 2/3 Name/Date of Birth: _____

Developmental History:

Motoric Development:			Age achieved / further information
Head support:	□YES	□NO	_____
Unsupported sitting:	□YES	□NO	_____
Walking without holding on:	□YES	□NO	_____
Trained for bowel/bladder:	□YES	□NO	_____
Does he/she have any accidents?	□YES	□NO	_____
Does child have difficulty sucking?	□YES	□NO	_____
Does child have difficulty chewing?	□YES	□NO	_____
Does child drool?	□YES	□NO	_____

Current diet: □Regular □Cut up foods □Baby Food stage_____ □other_____

Therapy:

			Name/Location/Phone number of therapist
Does your child receive Physical Therapy:	□YES	□NO	_____
Does child receive Occupational Therapy	□YES	□ NO	_____
Does child receive Speech Therapy	□YES	□NO	_____

If yes, indicate frequency of therapy per week:_____, for _____ minute sessions

Speech – Language Development:

Age child began to babble:_____
Age child began to use meaningful words:_____
Age child began to combine two to three words:_____
Current communication:
□Verbal / sentence level speech □ Verbal / few words □Vocalizing □Gesturing □ASL
Does your child understand directions: □YES □NO

Medical History:

Does the child have any of the following (past or present):

ADD/ADHD	□ YES	□ NO	Learning Disability	□YES	□NO
AIDS	□YES	□ NO	Heart Problems	□YES	□NO
Allergies	□ YES	□NO	High Fevers	□YES	□NO
Asthma	□YES	□NO	Diabetes	□YES	□NO
Cancer	□YES	□NO	Epilepsy	□YES	□NO
Chicken Pox	□YES	□NO	Hepatitis	□YES	□NO
Colds	□YES	□NO	HIV Positive	□YES	□NO
Ear Infections	□YES	□NO	Respiratory Disease	□YES	□NO
Gastric Reflux	□YES	□NO	Seizures	□YES	□NO
Hearing Loss	□YES	□NO	Mental Retardation	□YES	□NO
Cerebral Palsy	□YES	□NO			

Please list any other medical history, surgeries and medications along with dosages:_____
_____
_____

Educational History:

Does your child attend school? □YES □NO Where?_____
How many days per week?_____ Half or full day?_____
Grade:_____ Teacher's Name:_____
Does your child have any problems at school?_____
Please describe any special tutoring/therapy:_____
Does your child have difficulty with attention, learning, reading, spelling, writing, math? □NO □YES (explain)
_____
_____

Pediatric SLP Case History_page 3/3 Name/Date of Birth: _____

Family and Social History:

Has anyone in your family had?			Relationship to child
ADD/ADHD	□YES	□NO	_____
Trouble speaking clearly	□YES	□NO	_____
Hearing impairment	□YES	□NO	_____
Learning disability	□YES	□NO	_____
Mental retardation	□YES	□NO	_____
Genetic disorder	□YES	□NO	_____
Cleft lip/ cleft palate	□YES	□NO	_____
Speech delay	□YES	□NO	_____

Other:_____

Primary Language □English □Spanish □Other:_____

Does child speak a second language? (Please list)_____

What language does the child use most comfortably?_____

List any brother/sisters and ages?_____

Who lives in the home?_____

Marital status of parents?_____

Are there significant marital conflicts? □YES □NO

Do you think your child gets along well with other children? □YES □NO

Do you think your child gets along well with adults? □YES □NO

General Behaviors:

Does your child exhibit any of the following?

Clumsiness	□YES	□NO	Hitting	□YES	□NO
Tantrums	□YES	□NO	Biting	□YES	□NO
Head banging	□YES	□NO	Scratching	□YES	□NO

Other:_____

If so, in response to what and how often?_____

_____

Any other information that you feel would be important for us to know? _____

_____

_____

_____

_____ _____

Speech Pathologist's Signature Date/time