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Pediatric Case History

Date: ____/____/____

Name: _____

DOB: ____/____/____

Age: ____ years ____ months

Current School and Grade: _____

Physician: _____ Dentist: _____ Orthodontist: _____

Parent Name: _____ Phone: _____ E-mail: _____

Referral Source: _____ Phone: _____ E-mail: _____

Referral Source Address: _____

What are your concerns?

What languages are spoken at home? _____

Is there any history of speech, language, or hearing problems in the family? YES NO

If yes, please describe: _____

Who lives in the home?

Name	Age	Relationship

Pediatric Case History (Continued)

Describe any significant family medical, learning or emotional history.

Has your child been seen by other specialists? If yes, please describe.

MEDICAL HISTORY

Please describe any history of hospitalizations, illness, or accidents:

Does your child have any of the following? Check all that apply.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Frequent congestion | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Ear popping | <input type="checkbox"/> Kidney/urinary issues |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Frequent stomachaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other* |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dry/bloody nose | |

*Other: _____

BIRTH HISTORY

Length of pregnancy _____ Birth weight _____

Pregnancy or delivery complications? YES NO

If yes, please describe: _____

Did your baby require any special after care after delivery? YES NO

If yes, please describe: _____

Pediatric Case History(Continued)

DEVELOPMENTAL HISTORY

List the approximate age when your child first began to:

Hold head up _____	Roll over _____	Sit alone _____	Crawl _____
Walk unaided _____	Feed self _____	Babble _____	1st words _____
Combine 2 words _____	Combine 3+ words _____		

ORAL MOTOR

Has your child had excessive drooling? YES NO

Does or did your child suck his/her thumb or fingers? YES NO If so, for how long _____ /Current

Have any oral habits such as nail biting? YES NO If yes, describe: _____

Did your child use a pacifier? YES NO If yes, for how long? _____

Does your child grind his/her teeth? YES NO

Does your child lick, bite, and/or suck his/her lips (frequently chapped) ? YES NO

Does your child use a sippy cup? YES NO Straw top or tube-like top?

Does your child suck on his/her tongue? YES NO

Does your child chew his/her cheek and/or chew objects? YES NO

Other _____

FEEDING HISTORY

Was your child (circle): BREAST FED / BOTTLE FED

For how long? _____ If breast fed, did they receive bottle supplementation? _____

Did your child have any difficulties nursing or bottle feeding? YES NO

Breastfeeding only: Did it feel like you were feeding all day long? YES NO

Was your baby falling asleep frequently during feeding? YES NO

Did you suffer from sore nipples? YES NO

Was there a little blister on the center of the upper lip? YES NO

Was there green poop? YES NO

If yes, please describe: _____

What age did you introduce pureed foods? _____

What age did you introduce solid foods? _____

PRESENT EATING HABITS

Do you have any concerns about your child's feeding or nutritional status? YES NO

If yes, please describe: _____

Pediatric Case History (Continued)

Does your child have any food aversions? YES NO

Taste (sweet, salty, spicy, etc.) _____

Texture (puree, chewy, crunchy, soft, etc.) _____

Temperature (warm, cold, etc.) _____

Color _____

Size/shape _____

Other aversions: _____

Has your child been identified with a **tongue or lip tie**? YES NO

A **high palate**? YES NO

If yes, describe: _____

DENTAL HISTORY

Check all that apply

- | | |
|--|---|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Halitosis (bad breath) |
| <input type="checkbox"/> Gum disease | <input type="checkbox"/> Excessive plaque |
| <input type="checkbox"/> Chipped tooth/teeth | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Mouth sores- herpes simplex | <input type="checkbox"/> Mouth sores- canker |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Orthodontia (crowding, spaces between teeth) |

UPPER RESPIRATORY AND SLEEP

Does your child exhibit any of the following?

Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Mouth breathing/open-mouth posture | If yes: <input type="checkbox"/> Daytime <input type="checkbox"/> Nighttime |
| ----- | |
| <input type="checkbox"/> Snoring and/or heavy breathing in sleep | <input type="checkbox"/> Sleep walking |
| <input type="checkbox"/> Tossing and turning at night | <input type="checkbox"/> Sleep talking |
| <input type="checkbox"/> Night terrors | <input type="checkbox"/> Waking up during the night |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Tired throughout the day |

Pediatric Case History (Continued)

SENSORY INFORMATION

Does your child experience any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Easily upset | <input type="checkbox"/> Dislikes getting hands dirty | <input type="checkbox"/> Attention difficulties |
| <input type="checkbox"/> Difficulty calming | <input type="checkbox"/> Separation issues | <input type="checkbox"/> Difficulties with daily |
| <input type="checkbox"/> Difficulty sitting still | <input type="checkbox"/> Perseveration on objects/activities | living activities |
| <input type="checkbox"/> Difficulty transitioning | <input type="checkbox"/> Complicated bed/bath/meal routines | (brushing teeth, |
| from one activity to | <input type="checkbox"/> Covering ears in response to typical | washing hair) |
| another | sounds/noises | |

HEARING

Has your child had an audiological evaluation (hearing test)? YES NO Date: _____

Were the results normal? YES NO If no, please explain? _____

Have they experienced frequent ear infections? YES NO If yes, how many to date? _____

Have they had tubes in their ears? YES NO