NYCSPEECH-LANGUAGE PATHOLOGIST

475 White Plains Road, Suite 21,
Eastchester, NY 10709

521 Fifth Ave, 17th Floor, New York, NY 10175

www.speechtherapynyc.net
Phone: (914) 236-3365 | Fax: (914) 236-3364

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.

☐ Asthma	☐ Frequent sore throat	☐ Ear infections	☐ Heart condition
☐ Frequent congestion	☐ Difficulty swallowing	☐ Ear popping	☐ Kidney/urinary issues
☐ Food allergies	☐ GERD/Reflux	☐ Ear ringing	☐ Seizures
☐ Seasonal allergies	☐ Frequent stomachaches	☐ Dizziness	☐ Other*
☐ Frequent colds	☐ Constipation	☐ 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

- □ Cavities
- □ Gum disease
- □ Chipped tooth/teeth
- □ Mouth sores- herpes simplex
- □ Other: _____
- □ Halitosis (bad breath)
- □ Excessive plaque
- □ Jaw pain
- □ Mouth sores- canker
- □ Orthodontia (crowding, spaces between teeth)

UPPER RESPIRATORY AND SLEEP

Does your child exhibit any of the following?

Check all that apply.

- □ Mouth breathing/open-mouth posture If yes: □ Daytime □ Nightime
- □ Snoring and/or heavy breathing in sleep
- □ Tossing and turning at night
- □ Night terrors
- □ Bed wetting
- □ Sleep walking
- □ Sleep talking
- □ Waking up during the night
- □ Tired throughout the day

Pediatric Case History (Continued)

SENSORY INFORMATION

Does your child experience any of the following:

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

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