Medical Record Number

Patient Name

Patient Label

Rehabilitation Services Department
Speech-Language Pathology Services

CASE HISTORY FORM

Name of Client _____
(Last name, First name)

DOB _____ **Phone** _____ _____
(Home) (Cell)

BACKGROUND INFORMATION

Does your child have a diagnosis? _____ If yes, please list: _____

Describe your child's speech and/or language difficulties: _____
_____
_____

What languages are spoken in the home? _____

PREGNANCY, BIRTH AND DEVELOPMENTAL HISTORY

Were there complications during pregnancy or birth? _____ If yes, please explain:
_____
_____

Was your child born prematurely? _____ If yes, by how many weeks? _____

At what age did the following occur?
Sat Alone: _____ Crawled: _____
Stood Alone: _____ Walked Alone: _____
Said First Word: _____

Has your child demonstrated difficulty chewing food or swallowing liquid? _____
If yes, please describe: _____

Have you noticed unusual eating patterns of your child? _____ If yes, please describe:
_____

MEDICAL HISTORY

Is your child currently under medical treatment or on medication? _____ If yes, explain:
_____

Does your child have, or has he/she had any of the following conditions (please check):

Visual Difficulty _____	Hearing Difficulty _____	Ear Infections _____
Allergies _____	Seizures _____	Encephalitis _____
Impetigo _____	Measles_____	Mumps _____
Chicken Pox _____	Cleft Palate_____	Head injury_____
Meningitis_____	Other (not listed): _____	

Has your child received a speech and/or language evaluation previously? _____
If yes, list the following:
Date of Evaluation: _____ Location:_____ Results: _____

_____

Has your child received services from the following professionals? (please check)
Psychologist _____ Speech-Language Pathologist_____
Audiologist_____ Special Educator_____
Neurologist _____ Ear, Nose, & Throat Physician: _____

EDUCATIONAL HISTORY

What is the name of your child's current child care, preschool or school program?

_____

Location:_____ Start date:_____ Current Grade level:_____

Does your child currently participate in any therapies (Speech, OT, PT)? _____If yes, please list:

Type of therapy _____ How often_____ Reason for therapy_____

_____

SUMMARY:

Name of person completing this form: _____

Relationship to child: _____

Date completed: _____

Please send or fax the following forms to Speech-Language Pathology Services, LPCH, before your child's appointment:

1. Completed Case History Form.
2. A copy of your child's current IFSP (Individual Family Service Plan), IEP (Individual Education Plan), or other speech-language reports from outside clinics.

Thank you for taking the time to complete this form. It is an important part of the evaluation process and helps us to provide the appropriate evaluation for your child.

Lucile Packard Children's Hospital at Stanford
Speech-Language Pathology Services
321 Middlefield Road, Suite 130
Menlo Park, CA 94025
Phone: (650) 736-2000
Fax: (650) 736-3406