Patient Name

DOB:

MR #

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)

SPEECH PATHOLOGY PEDIATRIC CASE HISTORY

Date:_____

Please complete this form and bring to your appointment

I. GENERAL INFORMATION

Child's Name: _____ Date of Birth:_____ Sex:_____ Age: _____

Phone: _____ Mother's Name: _____ Father's Name:_____

E-mail address: _____ Insurance:_____

II. STATEMENT OF THE PROBLEM(S)

A. Tell us why you or someone else wants your child tested.

_____

B. When did you first notice the problem?

_____

III. PREGNANCY HISTORY

A. Were there any problems during pregnancy? YES NO

_____

IV. BIRTH HISTORY

A. Were there any problems at or right after birth? ("blue" at birth, oxygen required, bruises or abnormalities of head, drug used) YES NO

_____

B. Was your baby: PRETERM FULL TERM POST TERM

C. Birth weight _____

D. Did you have any trouble feeding? YES NO

V. MEDICAL HISTORY

A. Does your child take any medicine? YES NO

B. Does your child have any hearing problems? YES NO

C. Has your child ever had a hearing test? YES NO

D. Does your child have any vision problems? YES NO

E. Has your child ever been hospitalized? YES NO

F. Please check your child has had any of the following:

Pneumonia		
Meningitis		
Ear Infections		

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Chronic Colds		
Head Injuries/Concussion		
Asthma		
Allergies		
Encephalitis		
Surgery		
Seizures		
Other		

VI. GENERAL DEVELOPMENT

Please list the approximate age when your child did the following:

A. Motor: Sat alone _____ Crawled _____
Walked _____ Used a spoon _____

B. Speech/Language: First word _____ 2-word sentences _____

C. How often can you understand what your child says? Less than 50% Between 50-80% More than 80%

_____

D. How does your child let you know what they want? Words Gestures/Points Takes your hand Grunts

_____

E. How well does your child follow directions?

_____

F. Any family history of speech/language problems? YES NO

G. Has your child's speech/language been tested before? YES NO If YES, where and when?

_____

VII. EDUCATIONAL HISTORY

A. Does your child go to school/preschool/daycare? YES NO IF YES, how is your child doing in school/preschool/daycare?

_____

VIII. THERAPY SERVICES Please list any therapy services below

	Location	Frequency per week	How long in therapy
Speech			
PT			
OT			

IX. DAILY BEHAVIOR

A. Does your child sleep well? YES NO Eat well? YES NO

B. Does he/she tend to play alone with others? _____

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C. Does your child get along with: Other children their age? YES NO Adults? YES NO
Younger children? YES NO Older children? YES NO

D. What does your child play with? _____
E. Is it difficult to discipline your child YES NO
_____
F. Would you describe your child as basically: HAPPY UNHAPPY
G. Does your child have difficulty concentrating? YES NO

Please give any other information that would be helpful to us in evaluating your child?

_____
_____
_____
_____
_____
_____