CASE HISTORY FORM-CHILDREN

PATIENT

Name: _____ Date of Birth:_____ Age: _____Sex: ____

Address: _____ City _____State_____

Person who referred you: _____ Occupation_____

Address: _____

Child's physician: _____Phone: _____

Address: _____

Reason for referral: _____

How long has this communication difficulty been present?_____

List places your child has had previous evaluations or therapy:

Name **Address** **Date**

_____

_____

FAMILY

Mother's full name: _____ Level Of Education_____

Address: _____

Home Phone:_____ Work:_____ Cell:_____

Employer: _____Occupation: _____

Father's full name:_____ Level of Education_____

Address: _____

Home Phone: _____Work: _____ Cell: _____

Employer:_____ Occupation:_____

Children in Family **Age** **Communication problem, if any**

_____

_____

_____

Do any other family members have a speech or language problem? If so, please state relationship to your child and describe: _____

_____

MEDICAL /DEVELOPMENTAL HISTORY

List anything unusual in child's prenatal or birth history. _____

_____

At what age did your child:
Sit independently_____
Walk without help_____
Use single words_____
Combine 2 words _____
Become toilet trained_____

Is the child currently on any medication? If so, please list medications and reasons for taking:
_____

_____

Describe any additional physical or medical problems (including past hospitalizations or surgeries). _____

_____

EDUCATIONAL HISTORY

Where is your child currently in school?_____

Address: _____

Phone Number: _____Teacher's Name: _____

What grade?_____ Were any grades repeated or skipped?_____

Are there any concerns about school performance/behavior and if so, what?_____

_____

_____

What, if any, special services is the child receiving?_____

_____

ADDITIONAL INFORMATION

What would you like to learn from an evaluation? _____

_____

_____

Are you interested in therapy? _____ If so, what do you hope to achieve through therapy? _____

_____

_____

Are there any other issues you wish to mention or questions you wish to have answered?

_____

_____

Signature of person filling out this form _____

Relationship to patient _____ Date _____

Please return this form to:

TKL Speech and Language Services
7623 Dunleer Way
Dallas, Texas 75248