**CONFIDENTIAL**

Princeton Speech-Language & Learning Center

# PEDIATRIC CASE HISTORY FORM

The information you provide on this form will give us a better understanding of your child and will expedite the course of the speech and language evaluation process. All material and information is strictly confidential.

Date: _____

Person completing this form: _____

Relationship to child (parent, teacher, etc): _____

Description of the problem: _____

What information do you hope to obtain from this evaluation? _____

_____

**General Information**

CHILD'S NAME:_____ Date of Birth: _____

Address:_____ Phone:_____

_____ School District: _____

School: _____ Grade: _____

County: _____

E-mail address: _____

MOTHER'S NAME:_____ Cell phone:_____

Mother's occupation:_____ Business phone:_____

FATHER'S NAME:_____ Cell phone:_____

Father's occupation:_____ Business phone:_____

Referred by:_____ Phone:_____

Address: _____

Pediatrician/Primary Doctor:_____ Phone:_____

Address: _____

Dentist _____

Orthodontist _____

**Medical History**

Mother's general health during pregnancy (illnesses, accidents, medications, etc.):

Please describe any complications during pregnancy/delivery:

Please list at what age your child had or was diagnosed with any of the following conditions (if applicable):

| | | |
|---|---|---|
| Food Allergies: | Special Dietary Restrictions: | Other Allergies (type): |
| Ear infections: | Frequent Colds: (More than 6 per year) | Color blindness: |
| Headaches: | High fever: | Influenza: |
| Seizures: | Sinusitis: | Tonsillitis: |
| ADD/ADHD: | Snores: | Asthma: |

Autism Spectrum Disorder: Asperger Syndrome: Other:

Has your child had any surgeries? If yes, what type and when (e.g., tonsillectomy, adenoidectomy, etc.)?

Is your child up to date on their vaccines? Yes/No

Describe any major accidents or hospitalizations:

Is your child taking any medications? If yes, please list.

Have there been any negative reactions to medications? If yes, please describe.

**Developmental History**

Provide the **approximate age** at which your child began to do the following activities:

Crawl: Sit: Walk:

Feed self: Use toilet:

Use single words (e.g., no, mom, doggie, etc.):

Combine words (e.g., me go, daddy shoe, etc.):

Engage in conversation:

Does/Did your child ever use a pacifier/suck thumb or have an attachment to any other objects they put in their mouth? Yes / No

If yes, when, how often and under what conditions?

When did (s)he discontinue using the pacifier/sucking the thumb?

How does your child primarily communicate (gestures, single words, short phrases, sentences, conversation)?

Does your child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Are there or have there been any feeding or eating problems (e.g., any problems with sucking, tolerating specific food textures, swallowing, drooling, chewing, etc.)? If yes, please describe.

From what does your child primarily drink? (e.g. cup, straw, sippy cup, bottle)

Describe your child's response to sound (e.g., responds to all sounds, tolerate loud noises, responds to loud sounds only, inconsistently responds to sounds, etc.):

**Educational History**

Did / does your child attend preschool? Where, how many days/week, full/half days?

If applicable, does your child sit through circle time?

Has his/her teacher reported any concerns to you? Please describe.

Have you reported any concerns to the teacher? Please describe.

How is your child doing academically (or pre-academically)? Please comment on reading and written language.

Does your child like school?

Does your child enjoy reading?

Does your child enjoy being read to?

If your child is of school age, how would you describe his/her handwriting (neat, sloppy, average)?

Is your child classified? **If yes, state classification** (e.g. communication impaired, specific learning disability, etc…)

**Please indicate your child's educational setting and services. Circle all that apply. Where applicable, indicate <u>how many times per week</u>, <u>duration of sessions</u>, and <u>group or individual</u>.**

Regular Education

Fully mainstreamed  Partially mainstreamed (for:_____)

Self-Contained Class (type:_____)  Specialized School

Specialized reading curriculum (name:_____)  1:1 aide

Resource Room (for:_____)  Floortime

Basic Skills Instruction (for:_____)  ABA

Speech-language therapy  Occupational Therapy

Physical Therapy  Social Skills

**Social History**

Does your child live with both parents?_____

With whom does your child spend most of his/her time during the week? _____

Relationship to child? _____

Siblings (include names and ages):_____

Is English your child's primary language?  Y / N

If no, what other languages does the child speak?

Is your child aware of any difficulties they may be having?  Yes/No

If yes, how does he/she feel about it?

Are there any other speech, language, learning, reading, attention or hearing problems in your family?  If yes, please describe.

How does your child interact with others (e.g., shy, aggressive, inflexible, etc.)?

Does the child make friends easily?  Yes / No
Does your child have more success interacting with adults than peers?  Yes / No

Do you have any concerns about your child's social skills or ability to make/keep friends? Please describe.

**Pertinent Previous Testing and Therapeutic Intervention**

Please list other professionals currently involved with your child's care (Psychologist, Neurologist, Speech Language Pathologist, Occupational Therapist, Ear Nose Throat Doctor, tutors etc.)

Name: _____ Title:_____

Address:_____ Phone: _____

Name: _____ Title:_____

Address:_____ Phone: _____

Name: _____ Title:_____

Address:_____ Phone: _____

Name: _____ Title:_____

Address:_____ Phone: _____

Have any other speech-language specialists seen your child? If so, please describe.

Was your child ever evaluated for early intervention or by a child study team? If so, please describe.

Have any other specialists (tutors, physicians, psychologists, special education teachers, etc.) seen your child? If yes, indicate the type of specialist, and the reason why.

Please indicate date administered and results of the following (if applicable):

Vision Testing:

Hearing Test:

Central Auditory Processing Evaluation:

Please provide any additional information that might be helpful in the evaluation or remediation of your child's problem.

Princeton Speech-Language & Learning Center

## Financial Responsibility

I hereby agree to accept full responsibility for all fees for service rendered to the patient by the practitioner.

Signed: _____ Date: _____

Drivers License #: NJ – _____

## Cancellation Policy

Princeton Speech-Language & Learning Center is dedicated to providing quality services to our clients. We must stress that consistency of attendance is crucial in order for clients to effectively meet the goals of their treatment plan. In addition, therapy and tutoring time is specifically reserved for your family and is unavailable for other clients.

We are sensitive to the needs faced by the families of our clients however; it is necessary for us to enforce a cancellation policy. Except in cases of emergency or sudden illness, appointments not cancelled **48 hours** in advance will result in a charge as though the appointment was held.

We look forward to a positive relationship with you, as we strive to provide cutting edge, quality treatment and specialized programs. Thank you for your attention to this matter.

**Signed:** _____ **Date:** _____

Terri Rossman, *M.S., CCC, Executive Director* ♦ Mary Ann Raymond, *M.S., CCC, Director*
19 Wall Street, Princeton NJ 08540 ♦ Tel: 609-924-7080 ♦ Fax: 609-924-6563 ♦ info@psllcnj.com ♦ www.psllcnj.com

Princeton Speech-Language & Learning Center

## CLINICAL RELEASE OF INFORMATION

I,_____, hereby give Princeton Speech-Language & Learning Center permission to discuss my/my child's case with the interdisciplinary professionals involved in his/her care, and to release any relevant clinical information to those professionals if requested. I also authorize PSLLC to release and/or share any information requested by my insurance company.

_____ _____

Client's Name Relationship to Client

We would like to send a copy of the evaluation report to your child's pediatrician.

Pediatrician's Name: _____

Address: _____

_____

Phone: _____

In order to give feedback about your child, we encourage you to provide us with the names of other professionals/people responsible for your child's care. Please list the professionals to which we may correspond:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Parent or Guardian Signature: _____ Date: _____

Princeton Speech-Language & Learning Center

In order to assist the speech-pathologist get a complete profile of your child's strengths and weaknesses, please check off any areas which you feel may apply:

**Auditory Processing:**

_____ Does not listen carefully to directions - often need to repeat instructions.
_____ Sometimes misunderstands what is said.
_____ Needs extra time to respond to questions.
_____ Background noise makes following verbal instructions even more difficult.
_____ Says "huh" or "what" in response to questions.
_____ Does not respond to name when called.

**Listening:**

_____ Has trouble paying attention.
_____ Has trouble following spoken directions.
_____ Has trouble remembering things people say.
_____ Has trouble understanding what people are saying.
_____ Has to ask people to repeat what they have said.
_____ Has trouble understanding the meanings of words.
_____ Has trouble understanding new ideas.
_____ Has trouble looking at people when talking or listening.
_____ Has trouble understanding facial expressions, gestures, or body language.

**Attention:**

_____ Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
_____ Often has difficulty sustaining attention in tasks or play activities in school and at home.
_____ Has difficulty organizing tasks and activities.
_____ Often loses things necessary for tasks and activities (e.g., toys, school assignments, pencils, books, or tools).
_____ Fidgets with hands or feet or squirms in seat.
_____ Leaves seat in classroom or in other situations in which remaining seated is expected.
_____ Easily distracted.
_____ Often blurts out answers before the questions have been completed.
_____ Has difficulty awaiting turn.
_____ Daydreams and/or is inattentive.

**Speaking:**

_____ Has trouble answering questions people ask.
_____ Has trouble answering questions as quickly as other students.
_____ Has trouble asking for help when needed.
_____ Has trouble asking questions.
_____ Has trouble using a variety of vocabulary words when talking.
_____ Has trouble expressing thoughts.
_____ Has trouble describing things to people
_____ Has trouble getting to the point when talking.
_____ Has trouble putting events in the right order when telling stories or talking about things that happened.
_____ Uses poor grammar when talking.
_____ Has trouble using complete sentences when talking.
_____ Talks in short, choppy sentences.
_____ Has trouble expanding an answer or providing details when talking.
_____ Has trouble having a conversation with someone.
_____ Has trouble talking with a group of people.
_____ Has trouble saying something another way when someone doesn't understand.
_____ Gets upset when people don't understand.

***Word Retrieval:***

_____ Knows the word (s)he wants to say, but cannot think of it.
_____ Has difficulty remembering the names of people, places, objects that (s)he knows.
_____ Substitutes words with a similar word or by describing the word by category, function, or what it looks like.
_____ There is sometimes a long delay when (s)he cannot think of the word.
_____ Makes false starts and revisions when relating an experience (e.g., "we were…Bob and I went to the game.").
_____ Uses time fillers when trying to think of a word (e.g., um…er…um…computer).
_____ Gives too much information, includes irrelevancies

**Social Communication:**

_____ Decreased eye contact when interacting with others.
_____ Frequent conflicts with peers are noted by others such as teachers, scout leaders, etc.
_____ Avoids or shows no/little interest in social interactions of same age peers, such as birthday parties.
_____ Needs to be directly taught "implied social rules," such as keeping personal space, responding to others when they talk or greet them, how to talk to adults/authority figures vs. peers, messages sent by their tone of voice.
_____ Needs to be frequently given alternate solutions to conflict situations with peers- cannot generate these solutions, or only generates ineffective solutions on their own.
_____ Does not tell enough background information for the listener to understand his/her story.
_____ Has trouble staying on the subject when talking.

***The following may or may not be applicable to your child.***

_____ Not applicable

**Reading:**

_____ Has trouble sounding out words when reading.
_____ Has trouble understanding what was read.
_____ Has trouble explaining what was read.
_____ Has trouble identifying the main idea.
_____ Has trouble remembering details.
_____ Has trouble following written directions.

**Writing:**

_____ Has trouble writing down thoughts.
_____ Uses poor grammar when writing.
_____ Has trouble writing complete sentences.
_____ Writes short, choppy sentences.
_____ Has trouble expanding an answer or providing details when writing.
_____ Has trouble putting words in the right order when writing sentences.

**Sensory Sensitivities:**

_____ Expresses distress during grooming (e.g., haircuts, face washing, teeth brushing, nail cutting).
_____ Reacts emotionally or aggressively to touch.
_____ Avoids certain tastes or food smells that are typically part of children's diets.
_____ Picky eater, especially regarding food textures.
_____ Becomes anxious or distressed when feet leave the ground.
_____ Touches people and objects.
_____ Doesn't seem to notice when face or hands are messy (e.g., with food, drool, mucous, etc.).