SPEECH LINK

Case History Form

Patient's name:

PARENT / GUARDIAN INFORMATION

Parent / Guardian's name:	Relationship:	Birth date: / /
Street address:		City:
State & Zip code:	Cell phone:	Work phone:	Occupation:
Email address:		Preferred method of contact:

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Street address:		City:
State & Zip code:	Cell phone:	Work phone:	Occupation:
Email address:		Preferred method of contact:

Siblings and ages:

REFERRAL INFORMATION

Reason for referral:	Referred by:

HISTORY OF PROBLEM:

Describe present problem:

Have there been any significant changes in the last 6 months?: Yes/No

If yes, please explain:

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If yes, please explain: _____

PREGNANCY/BIRTH HISTORY

Did any of the following events occur during this pregnancy?: (Circle all that apply)

Allergies/Asthma	Anemia	Diabetes/Blood sugar problems	Edema
Excessive Vomiting	Heart Disease	Headaches/Migraines	Kidney Disease
Pre-Eclampsia	Rh Negative	Toxemia	Toxin Exposure
Blood Transfusions	Accidents	Bleeding/Spotting	Cervical Incompetence
Infections	Pre-term labor	Uterine/uterine fluid problems	Other: _____

Please explain any circled items: _____

Were medications, drugs, or alcohol used during pregnancy? Yes/No

If yes, please explain: _____

Length of pregnancy: _____ Birth weight of child: _____ Length of labor: _____

Number of days spent in the nursery: _____ NICU: _____ Type of delivery: C-section/Vaginal

Any complications *during* labor and delivery for mother or child?: (Circle all that apply)

Maternal Infection	Low/High red/white blood cell count	Pelvis or cervical problems
Placenta Problems	Baby had cord around neck	Dysfunctional Labor
Baby had high/low heart rate	Cord problems (knots, prolapsed, compression)	Baby had heart rate decelerations
Fetal distress noted	Meconium was noted	

Please explain any circled items: _____

Any medical problems for child *after* birth?: (Circle all that apply)

Blue/cyanotic at birth	Required stimulation to breathe	Required oxygen at birth	Infections
Tremoring/seizures	Considered small for age	Very low tone	Brain hemorrhage
Anemia/Transfusions	Rh incompatibility problems	Jaundice	Bruising
Required resuscitations	Congenital birth defects	Aspiration (meconium/fluid)	Ventilation
Tube Feedings	Respiratory distress/symptoms	Choking/Vomiting episodes	Medications

Please explain any circled items: _____

CHILD'S MEDICAL HISTORY

(Circle all that apply)

Seizures	High Fevers	Measles	Chicken Pox	Mumps	Diphtheria
Pneumonia	Tonsilitis	Meningitis	Sinusitis	Tuberculosis	Reflux
Encephalitis	Chronic Colds	Heart Trouble	Whooping Cough	Rheumatic Fever	Birth defect
Head Injury	Genetic Disorder	Constipation	Frequent Diarrhea	Poor weight gain	Feeding problems
Vision Problems	Hearing Problems	Dental Problems	Autism/PDD	Cerebral Palsy	Neurological
Croup	Thyroid	Asthma	Eczema	ADHD	

Please explain any circled items: _____

_____

Are immunizations current?: Yes/No Current general health: _____

Any nutritional concerns?: Yes/No If yes, please explain: _____

_____

Any feeding or swalling problems?: Yes/No If yes, please explain: _____

_____

Has your child any ear aches/infections?: Yes/No Last hearing screen/test: _____

If yes, please explain: _____

Allergies?: Yes/No If yes, please explain: _____

_____

Has your child experienced any regression?: Yes/No If yes, please explain: _____

_____

Recent operations or accidents?: Yes/No If yes, please explain: _____

_____

Current medications?: Yes/No

Medication	Reason for taking