PEDIATRICS FIRST LLC

Michelle Stewart-Tooson, M.A.,CCC-SLP
Director/Lead Therapist

12841 Braemar Village Plaza #132 Bristow VA 20136
(703)367-0400 Phone
Email: pediatricsfirst@hotmail.com

CASE HISTORY FORM

Child's Name:____

Date of Birth:_______________________ Age:___________ _______Sex:_______________

Parent(s)/Guardian:____

Mailing Address:____

Home Phone:_________________________________Work Phone:_____________________

Cellular Phone:_______________________________ Email:____________________________

Primary Language:____________________Other Languages:________________________

Referral Source:___________________

Reason for Referral [Check Problem Area(s)]:

Articulation-Difficulty using speech sounds clearly
Language-Difficulty understanding language or using language to express wants/needs
Voice-Vocal quality is hoarse, strained or nasal
Oral-Motor-Lips, cheeks or tongue appear droopy, difficulty with drooling
Feeding-Refusal to try new textures in and around the mouth, frequent gagging/vomiting when presented with unfamiliar tastes/textures

____Articulation _____Language _____Voice
____Oral-Motor _____Feeding
____Other (please specify)____
Has your child ever been given a medical diagnosis?___________ If so please explain:____
Pregnancy/Birth History
Number of weeks pregnant prior to delivery:_________________ Please describe any pregnancy complications or conditions experienced:

Did the child experience any breathing or swallowing/feeding problems following discharge from the hospital? If so please explain________________________________
Was the child adopted?____________
Any information available on birth history (if adopted)?_____________
Please describe any labor/delivery or medical complications:____
____
(for adoptive parents) Please note the country of birth and primary language:____________________________

Medical/Developmental History

Please describe any illnesses, surgeries, or other conditions the child has experienced since birth:
____
____

Does your child gag?____________ Cough/choke/vomit during meals?_________________________

Does or did your child take a pacifier, explore toys orally, tolerate toothbrushing?________________
______________________________Any digestive problems?____________________ Does your child eat a variety of foods?____________ Any abnormal eating/feeding patterns?____________________

Please list the age your child began displaying the following skills:

Sitting up alone:________________ Crawling:______________ Walking:_____________

Babbling/Jargon:_______________ First Word(s):__________Self-feeding:__________

Two word Phrases:______________ Potty-training:_________

Please briefly describe your child's gross motor (running, jumping) and fine motor (coloring) skills:
____

Is the child currently receiving OT or PT services?________________ Would you like more information regarding occupational therapy or physical therapy services?________________________

Has your child ever had a hearing evaluation? Please indicate the date of the test and the results
____

Social/Behavioral History

Please list all parties that reside at the child's residence.

Name Age Relationship to the child

____
____
____
____ _

Does the child go to school? Stay at home with mom during the day? Participate in playgroups? Please explain:____
________________________Name of school ______________________Teacher___________Class/Grade

Has the child previously received speech therapy? If so please describe:____How would you describe your child's social interactions? Does the child have many friends? Experience frequent tantrums? Any sleeping problems? Please explain:___________________________________

Please use the following space to write any additional information, concerns, or questions you have regarding the child's communication and/or feeding skills: