Patient Name:
Evaluation Date:
DOB:

Child Case History

Please complete the following information about your child to assist the therapist in evaluating your child. If a question does not apply to your child, please mark "N/A". If you are unsure how to answer a question, please leave it blank and the therapist will discuss it with you at the time of the evaluation.

Date: ________________________________

Demographics

Child's Name: ____ DOB: __________________ Age: __________

Child's Primary Language: *English / Spanish / Other:* ____

Does the child live with both parents? *Yes* *No*

Parent's Names: ____

Psychosocial concerns: ____

Who does the child spend most of his/her time with? ____

Referral Information

What information do you want to receive from this evaluation? ____

____

Was this evaluation recommended by another professional? *Yes* *No*

If yes, by who, and what concerns were shared with you? ____

____

Describe your concerns regarding your child: ____

____

____

When did you first notice a problem? ____

Describe your goals for your child ____

____

Birth History

Was pregnancy full-term? *Yes* *No* Gestational Age (weeks): _________ Weight at birth: _________

Type of Delivery: *C-section / Vaginal / Head First / Feet First / Breech / Other*: ______________________________

Were there any complications with delivery? *Yes* *No*

If Yes, please explain: ____

Were there any breathing or swallowing complications at birth? *Yes* *No*

If Yes, please explain: ____

Did your child require a NICU stay? *Yes* *No*

If Yes, please explain: ____

Was your child intubated? *Yes* *No*

If Yes, length of intubation: ____

Did your child require supplemental nutrition? *Yes* *No*

If Yes, please explain: ____

Was your child discharged home with supplemental feeds? *Yes* *No*

Please note any additional birth history information you think is relevant: ______________________________

____

____

____

Medical History

List all diagnoses (of any kind) your child has: ____

____

____

List all current medications your child takes: ____

____

____

Does your child have any durable medical equipment used at home? *Yes* *No*

If yes, list equipment: ____

Has your child been hospitalized? *Yes* *No*

If Yes, please explain: ____

____

____

Has your child had any major illnesses? *Yes* *No*

If Yes, please explain: ____

____

____

Has your child had any surgeries? *Yes* *No*

If Yes, please explain: ____

____

____

Is your child followed by any medical professionals? *Yes* *No*

If yes, by whom? ____

Has your child had any of the following procedures? *(please circle)*

Video Fluoroscopic Swallow Study *Upper GI*

Fiberoptic Endoscopic Evaluation of the Swallow *MRI*

Bronchoscope and Laryngoscope *CT Scan*

Botox *X-Ray*

Other: ____

If Yes, what were the results? ____

Neurology

Does your child have a history of seizures? *Yes* *No*

If Yes, please explain: ____

Has your child had any head injuries or concussion? *Yes* *No*

If Yes, please explain: ____

Does your child have a history of any other neurological conditions? *Yes* *No*

If Yes, please explain: ____

Ear/Nose/Throat

Does your child have a history of ear infections? *Yes* *No*

If Yes, how many? _________________________

Were ear tubes placed? *Yes* *No*

If Yes, when? ______________________________________

How is your child's hearing? *Normal* *impaired*

If impaired, what degree of loss? *Mild* *moderate* *severe* *profound* *uncertain*
uncertain as patient may hear yet not react

Is patient aided? *No aid* *unilateral cochlear implant* *bilateral cochlear implant* *unilateral hearing aide* *bilateral hearing aid* *unknown device* *other*

Vision

Does your child have a vision impairment? *Yes* *No*

If Yes, please explain: ___________________________

Respiratory

Has your child had pneumonia or upper respiratory infections? *Yes* *No*

If Yes, how many? ___________________________

Does your child have a history of asthma or wheezing? *Yes* *No*

Circle the options that best describe your child's breathing:

Breathing room air *Oxygen Needed*

Noisy Breathing *Asthma*

Retractions *Supplemental Ventilation*

Other: ____

How would you describe your child's sleep patterns? *No concerns / waking at night / snoring / mouth breathing*

other: ____

Gastroenterology

Does your child have a history of reflux or vomitting? *Yes* *No*

If Yes, please explain: ____

Does your child have a history of constipation? *Yes* *No*

If Yes, please explain: ____

Does your child have a history of diarrhea? *Yes* *No*

If Yes, please explain: ____

Has your child demonstrated difficulty gaining or maintaining weight? *Yes* *No*

If Yes, please explain: ____

Has your child ever had an alternate means of nutrition? *Yes* *No*

If Yes, please explain: ____

Speech and Feeding of Frisco, LLC
Comprehensive and Compassionate Pediatric Therapy

Patient Name:
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DOB:

Allergies/Immunology

Does your child have food allergies? Yes *No Known Allergies*

If Yes, list allergies and reactions: ____

____

Does your child have any environmental allergies? *Yes* *No*

If Yes, list allergies and reactions: ____

____

Does your child have any dietary restrictions? *Yes* *No*

If Yes, list allergies and reactions: ____

____

Are immunizations up-to-date? *Yes* *No*

Educational Status/Grade

Is your child in school or a mother's day out program? *Yes* *No*

If Yes, please explain: ____

Has your child been held back a grade or repeated a grade? *Yes* *No*

If Yes, please explain: ____

Does your child receive tutoring services or special education services? *Yes* *No*

If Yes, please explain: ____

Developmental Status

Place a checkmark next to the developmental milestones your child has met along with the approximate ages your child met these milestones:

☐ Rolled: ________	☐ Walked: ________	☐ Used Single Words: ________
☐ Sat up: ________	☐ Fed Self: ________	☐ Combined Words: ________
☐ Crawled: ________	☐ Used cup: ________	☐ Engaged in Conversation: ________
☐ Stood: ________	☐ Dressed self: ________	

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Comprehensive and Compassionate Pediatric Therapy

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Does your child receive speech, physical or occupational therapy services through the school district at this time? *Yes* *No*

If yes, how often? ____

Name of child's therapist(s): ____

Phone number(s): ____

Has your child had previous treatment or by a speech, physical or occupational therapist? *Yes* *No*

If yes, by whom? ____

What were the results? ____

Does your child receive any other therapy? *Yes* *No*

If yes, what kind and how often? ____

Language/Articulation Information

How does your child communicate? *gestures* *single words* *short phrases* *sentences* *conversation*

Approximately how many words does your child say? ____

How does your child let you know what he/she wants? ____

What does your child do when you do not understand? ____

Describe how your child interacts with other children? ____

Is your child aware of his/her difficulties? *Yes* *No* *Unsure*

Voice

Note any concerns you have with your child's voice: ____

____

____

____

Please check any behaviors you notice frequently in your child:

- ☐ frequent yelling
- ☐ harsh onset of voice
- ☐ frequent coughing
- ☐ frequent throat clearing
- ☐ other: ____
- ☐ none observed

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Fluency

Describe the rate of your child's speech (too fast, slow, normal, etc.): ______________________________________

Does your child repeat words or parts of words frequently? *Yes* *No*

If Yes, please explain: ____

Feeding Information

Place a checkmark next to the feeding milestones your child has achieved:

☐ None	☐ Stage 1 baby food	☐ Spoon	☐ Straw
☐ Breast Feding	☐ Stage 2 baby food	☐ Fork	☐ Cup
☐ Bottle Feeding	☐ Dissolvable solids	☐ Knife	☐ Pours Drink
	☐ Finger Foods		

Does/Did your child use a pacifier? *Yes* *No*

If Yes, what age did your child stop? ___________________

Describe how the weaning process from the breast and/or bottle went and why your child was weaned: _____

____

____

How did your child handle moving between the stages of feeding milestones? _____________________________

____

____

Does your child cough or choke with feeding? *Yes* *No*

If Yes, how often and when? ____

Describe mealtime to me. Who is with the child, where does the child sit, what is the environment like, is special equipment used, etc.: ____

____

____

____

____

Describe your child's appetite: ____

____

____

How long does a typical meal last: ____

How does your child respond when presented with a food item he or she does not like? ____________________

____

____

____

Tube Feedings

If your child is tube fed, please provide their feeding regiment for a whole day: ___________________________

____

____

____

Describe where your child is tube fed and what activities are occurring at the same time: ___________________

____

____

____

Describe your child's reactions to the tube feedings: ____

____

____

____

____
Name of Clinician completing form

____
Name of Caregiver(s) reporting information