SMALL TALK, LLC

CASE HISTORY

Child & Family Information:

Today's date_____

Child's name_____ Age _____

Nickname_____ Date of Birth_____

School_____ Grade_____

Address_____

City_____ State_____ Zip Code_____

Parents' Names_____

Sibling(s)_____ Age(s)_____

Other relatives or persons living in household_____

Mother's occupation_____ Work phone_____

Father's occupation_____ Work phone_____

Home phone_____ email_____

Mother's cell phone_____ Father's cell phone_____

Primary language spoken in the home_____ Additional languages_____

Family history of speech, language or feeding difficulties_____

Referred by_____

Pediatrician_____ Telephone_____

Birth History:

Pregnancy complications_____

Medications taken during pregnancy_____

Length of Pregnancy_____

Labor: Normal_____ Induced_____ C-Section_____

Birth complications_____

Birth weight_____ Apgar Scores_____

Medical History:

Existing Diagnoses_____

Does your child have a history of any of the following childhood illnesses or disorders? If so, please check box and give number of occurrences if greater than one.

☐ **Ear infections_____Ear tubes_____**

☐ **Colds_____**

☐ **Fevers**_____

☐ **Pneumonia**_____

☐ **Strep Throat**_____

☐ **Chicken Pox**_____

☐ **Asthma**_____

☐ **Seizures**_____

☐ **Other**_____

Allergies_____

Previous and Current Medications_____

Surgeries_____

Hospitalizations_____

Has your child's vision been formally tested_____ **Results**_____

Has your child's hearing been formally tested_____ **Results**_____

Developmental History: (please give an approximate age)

Sitting up unsupported_____ **Crawling_____**

Standing_____ **Walking_____**

Cooing_____ **Babbling_____**

First word_____ **Imitating words_____**

Combining words_____

What are your concerns regarding your child's speech and language development?

_____

Does your child use an alternative form of communication (i.e., sign language, gestures, augmentative communication, etc.)_____

Does your child seem to:

understand what you are saying to him/her_____

follow multiple step directions_____

easily imitate new sounds and words_____

effectively communicate his/her wants and needs_____

Feeding History:

Breast fed_____ **Age when child was weaned_____**

Bottle fed_____ **How long_____**

Please give the approximate age for the following:

Sippy cup_____ **Open cup_____**

Pureed food_____ **Table food_____**

What are your concerns, if any, regarding your child's feeding development?

_____

Treatment History:

Please list any additional therapies (speech and language, occupational, physical, vision, etc…) your child is currently receiving or has received in the past. Please give the dates of treatment as well.

_____

_____

If referred for speech, language or feeding therapy by a physician, please list additional therapies recommended:_____

Thank you