Case History Form

Date: ______________
Client Name: ___________________________________
Address: ____
____ Tel: _______________
Date of birth: _______________ Place of birth: ________________________
Referred by: ____
Name of person completing form: ____
Physician name & address: ____
____
Insurance information: ____

FAMILY

Father:
Name: _____________________________ Age: ______________
Occupation: ___________________
Employment: ____
Telephone (Home): ___________________ (Cell): __________________

Mother:
Name: _____________________________ Age: ______________
Occupation: ___________________
Employment: ____
Telephone (Home): ___________________ (Cell): __________________

Brothers and sisters:

(Name)	Age	(Name)	Age
___________________	_______	___________________	______
___________________	_______	____________________	______
___________________	_______	____________________	______

Medical, Developmental and Family History

Describe mother's health during pregnancy and birth history (i.e. any complications).
____
____

Describe any development problems during pregnancy or early childhood (i.e., late walking, feeding problems, food allergies, late in talking) __________________________
____

Do you think the child's speech and language development was unusually rapid or delayed? If so please describe.____
____

List any illnesses, injuries, and operations:

Name Date Fever Complications Treatments Name of physician

List any present physical disabilities.____

Any chronic illnesses, allergies or physical conditions?______________________________

____

Vision normal? _____ Hearing normal? ______

Do other members of the family have speech, language, or reading problems or learning disabilities? If so please describe. ____

Are any family members left-handed, or do they use both hands equally well? _______

____

Does any family members talk very rapidly? If so, who?____________________________

____

School and Social History

Difficult subjects. ____

Hobbies ___________________________ Sports _______________________________

Leisure time activities ____

When did your communication difficulty first begin and what did you try to make things better? _____________________________

What specific questions do you have that you would like us to try and answer?

____

____

____

What goals would you like to see accomplishes as a result of this evaluation? _________

____

____

If, in order to provide optimum treatment, it is appropriate to send reports to other agencies or professional persons, or to contact other agencies and professional persons, please indicate your permission by signing below.
I authorize and request John Peats to obtain or exchange pertinent medical/educational information. I understand that all information will be kept confidential.
Name: ____
Relationship to client: ____
Date: ____
Signature: ____