***letterhead.TIFFamily Speech Center***

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**Child Case History Form**

**CONFIDENTIAL AND PRIVILEGED INFORMATION**

Date:

Person completing this form:

Relationship to the patient:

Patient’s Name: Sex:

Date of Birth: Age:

Address: City/State: Zip:

Home Phone: Cell Phone:

E-Mail Address:

Reason for evaluation:

Name of person who referred you:

Address:

City/State: Zip: Phone:

Name of Orthodontist:

Address:

City/State: Zip: Phone:

Name of General Dentist:

Address:

City/State: Zip: Phone:

Name of Physician:

Address:

City/State: Zip: Phone:

School: Grade:

Principal:

Address:

City/State: Zip: Phone:

**FAMILY:**

Person(s) responsible for this account:

Name:

Address:

City/State: Zip: Phone:

Father’s Full Name:

Date of Birth: Age: Marital Status:

Employer: Occupation:

Business Address:

City/State: Zip: Phone:

Mother’s Full Name:

Date of Birth: Age: Marital Status:

Employer: Occupation:

Business Address:

City/State: Zip: Phone:

Other children in family, ages, problems, if any:

**PRENATAL AND BIRTH HISTORY:**

During this pregnancy, describe the mother’s experience with any unusual illness, condition, or accident, such as German Measles, false labor, RH incompatibility, etc.:

Length of Pregnancy: Duration of Labor:

Birth Weight: Condition at Birth:

Caesarean? Jaundiced? Other unusual conditions:

Are you on any medications at this time?

If so, please list:

Describe any additional physical or medical problems, including past hospitalizations or surgeries:

**DEVELOPMENT:**

When did the patient sit alone?

When did the patient walk alone?

When did the patient say first words?

When did the patient combine words?

Does the patient prefer the right or left hand?

Bottle or breast-fed? If breast-fed, for how long?

Was a bottle used for supplemental feeding?

Did the patient as a baby experience colic?

Did the patient as a baby refuse to accept the bottle?

Were there any feeding difficulties?

Was the patient easily weaned? At what age?

Did the patient take solids easily?

**PRESENT EATING HABIT:**

Is the patient a fast or slow eater?

Does the patient drink much liquid with his/her meals?

Does the patient chew his/her food with their mouth open?

Does the patient gulp his/her food or liquid?

Is the patient a noisy eater?

**SUCKING HABITS**

Does the patient suck his/her thumb? Finger?

Knuckle? Lips? Blanket? Pacifier? If so, has anything been attempted to stop the sucking habit? What has been done? What success have you had?

**NERVOUS DISEASES**

Does the patient have any nervous diseases?

Does the patient suffer from epileptic seizures?

Does the patient have a tendency to be tense and/or nervous?

Have you had any type of counseling or psychotherapy?

**OTHER CONDITIONS:**

Does the patient have any allergies?

Can the patient swallow pills?

Is the patient a mouth breather?

Has the patient ever worn ay type of orthodontic appliances?

If so, what type and for how long?

Please describe the patient’s problems for which you are seeking help. Also, give any other concerns you have which contribute to the difficulty. What have you been told about the cause of the patient’s problems? What has been done about the patient’s problems?

**MEDICAL**

If the patient has had any of the following, indicate at what age and the degree of severity.

|  |  |
| --- | --- |
| **Age/Severity** | **Age/Severity** |
| Whooping Cough | Ear Aches |
| Mumps | Running Ears |
| Scarlet Fever | Chronic Colds |
| Measles | Head Injuries |
| Chicken Pox | Venereal Disease |
| Pneumonia | Asthma |
| Diphtheria | Allergies |
| Influenza | Encephalitis |
| Polio | High Fevers |
| Headaches | Typhoid |
| Sinus | Tonsillitis |
| Meningitis | Tonsillectomy |
| Rickets | Adenoidectomy |
| Rheumatic Fever | Mastoidectomy |
| Pleurisy | Thyroid |
| Tuberculosis | Heart Trouble |
| Small Pox | Enlarged Glands |
| Croup | Convulsions |

Person completing form:

Relationship to Client:

Signed: Date: