Baileigh Landrum, CCC-SLP
phone 504-578-0251
email blandrum30@outlook.com

Case History

CHILD'S FULL NAME: ____

DATE OF BIRTH: ______________________________ AGE: ____________ SEX: M / F

ADDRESS: ________________________ CITY: _________ STATE: ______ ZIP: ______

MOTHER'S NAME: ____

OCCUPATION: ____

HOME PHONE: ____________________ CELL: ____________ WORK: ____________

ADDRESS (if different from above): ________________________________

EMAIL: ____

FATHER'S NAME: ____

OCCUPATION: ____

HOME PHONE: ____________________ CELL: ____________ WORK: ____________

ADDRESS (if different from above): ________________________________

EMAIL: ____

CHILD RESIDES WITH: _____ BOTH PARENTS _____ MOTHER _____ FATHER _____ OTHER, ____________

LANGUAGE(S) SPOKEN IN THE HOME: ________________________________

OTHER PERSONS LIVING IN THE HOME:

NAME	SEX	AGE	RELATIONSHIP	RELATED PROBLEMS

Family history of speech, language, hearing issues or therapy _____ N _____ Y,

Describe ____

SCHOOL: ____________________________ GRADE: _____ TEACHER: ______________

REFERRED BY: ____

CONCERNS: ____

____

Case History p2

Any pregnancy and/or birth complications? _____ N _____ Y,
Describe ____

Full term / Premature, born at _________ weeks

Hospitalized after birth _____ N _____ Y   Weight at birth _______________ lbs., oz.

Did your child pass the newborn hearing test? _____ N _____ Y

Has your child's hearing been tested since birth? _____ N _____ Y, results ______________________________

Placement of pressure equalization tubes? _____ N _____ Y, when? ______________ still present N / Y

Has your child's vision been tested? _____ N _____ Y, results ____

Any difficulty with feeding/swallowing as a baby? _____ N _____ Y,
Describe ____

Check any known medical conditions:

_____ allergies, describe ____

_____ food allergies, describe ____

_____ adenoidectomy _____ breathing difficulties _____ ear infections _____ high fever _____ flu _____ head injury

_____ measles/chickenpox/mumps _____ seizures _____ sinusitis _____ sleeping difficulties _____ tonsillectomy

_____ reflux _____ thumb/finger sucker _____ ADHD _____ Autism _____ other, ___________________________

Has your child ever been hospitalized? _____ N _____ Y,

Describe ____

Is your child taking any medication? _____ N _____ Y,

Describe ____

Has your child received evaluations and/or treatment in the areas of speech, language, reading, occupational, and/or physical therapy? _____ N _____ Y,

Describe ____

Has your child been seen by any other health professionals (i.e psychologist, neurologists, etc.) _____ N _____ Y,

Describe ____

Please add any other significant information regarding your child and his/her treatment:

____

____

This form was completed by: ____

Relationship to child: ____ Date: ___________________________