



**Pediatric Case History**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Name of Guardian(s): \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy#: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's #: \_\_\_\_\_

**Other Children in the Family:**

Name	Gender	Age /Grade	Speech/Hearing Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Is there a language other than English spoken in the home?** Yes No

If yes, which one? \_\_\_\_\_

Does the child speak the language? Yes No

Does the child understand the language? Yes No

Who speaks the language? \_\_\_\_\_

Which language does the child prefer to speak at home? \_\_\_\_\_

**Birth & Medical History:**

**Delivery:**

Duration of labor: \_\_\_\_\_ Term: \_\_\_\_\_ Birth Weight \_\_\_\_\_

Normal \_\_\_\_\_ Instrument \_\_\_\_\_ Breech \_\_\_\_\_ Caesarian \_\_\_\_\_

Unusual conditions at or immediately after birth \_\_\_\_\_

**Speak Easy Rehabilitation, PLLC**  
**PO Box 2023 Fuquay-Varina, NC 27526**  
**Phone: 919-346-3350-Fax: 919-285-2554**  
**Website: www.speakeasyrehab.com**

# SPEAK EASY REHABILITATION

## Medical History

Age	Severity	Age	Severity
Chicken Pox _____	_____	Encephalitis _____	_____
Measles _____	_____	Mumps _____	_____
Scarlet Fever _____	_____	Meningitis _____	_____
Allergies _____	_____	Whooping Cough _____	_____
Pneumonia _____	_____	Head Injuries _____	_____
Influenza _____	_____	High Fevers _____	_____
Asthma _____	_____	Ear Infections _____	_____
Seizures _____	_____	Other _____	_____

Vision and/or Hearing Concerns: \_\_\_\_\_  
\_\_\_\_\_

Date of Last Hearing Screening: \_\_\_\_\_

Does your child have any medical or school related diagnosis? If yes, please list and include who made the diagnosis and when was it made. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child currently take any medications? If yes, please list the medication and for what condition it is taken. Please list any behaviors your child exhibits that you believe might be attributed to taking the medication. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone	_____ grasped crayon/pencil
_____ babbled	_____ said first words
_____ put two words together	_____ spoke in short sentences
_____ walked	_____ toilet trained

## Does your child...

Choke on food or liquids? Yes No      Currently put toys/objects in his/her mouth? Yes No  
Brush his/her teeth and/or allow brushing? Yes No

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**Current Speech/Language and Hearing**

**Does your child...**

- repeat sounds, words or phrases over and over?
- understand what you are saying?
- retrieve/point to common objects upon request (ball, cup, shoe)?
- follow simple directions (“Shut the door” or “Get your shoes”)?
- respond correctly to yes/no questions?
- respond correctly to who/what/where/when/why questions?

**Your child currently communicates using...**

- body language.
- sounds (vowels, grunting).
- words (shoe, doggy, up).
- 2 to 4 word sentences.
- sentences longer than four words.
- other \_\_\_\_\_.

**Behavioral Characteristics:**

- cooperative
- willing to try new activities
- plays alone for reasonable length of time
- destructive/aggressive
- restless
- inappropriate behavior
- attentive
- easily distracted/short attention
- separation difficulties
- easily frustrated/impulsive
- stubborn
- poor eye contact
- withdrawn
- self-abusive behavior

**Additional Comments/Concerns:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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