

 Evaluation Case History Form

|  |  |
| --- | --- |
| Name: | Date of Birth: |
| Address: | Home:Cell: |
| Referral Source: | Email: |
| Mother’s Name/Age/Occupation | Father’s Name/Age/Occupation |
| Whole lives in the home? | Pediatrician name and address: |
| School Placement/Early Intervention Info: | Dentist name and address: |
| Languages Spoken: | List any History of Medical or Educational Diagnoses in the immediate family: |

**Briefly, what is the reason(s) for this evaluation?**

**Birth History (please provide details where applicable)**

Were there any complications during pregnancy? \_\_\_\_yes \_\_\_\_no (if yes explain)

Did you carry your baby full term? \_\_\_\_yes \_\_\_\_no (if no explain)

Were there problems during delivery? \_\_\_\_yes \_\_\_\_no (if yes explain)

Did your baby require any special care after delivery? \_\_\_\_yes \_\_\_\_no (if yes please explain)

Please indicate your child’s:

birth weight \_\_\_\_\_\_\_\_\_\_ length/ height \_\_\_\_\_\_\_\_ Apgar score \_\_\_\_\_\_\_\_\_

Percentile of weight \_\_\_\_\_\_\_\_\_\_\_\_\_ Percentile of length/height \_\_\_\_\_\_\_\_\_\_\_

**Developmental History:**

At what age did your child develop these skills (feel free to write notes/complications)

|  |  |
| --- | --- |
| Roll over |  |
| Sit up |  |
| crawl |  |
| walk |  |
| First vocalize |  |
| Self-feed |  |
| Say first word |  |
| Say 2–3-word phrases |  |
| Talk in sentences |  |
| Toilet train |  |
| Attend school |  |

Are there developmental concerns? \_\_\_\_\_yes \_\_\_\_\_\_no

Does your child have a global diagnosis (Down syndrome, autism etc.)? \_\_\_\_\_yes \_\_\_\_\_\_no

If yes, please explain:

Does/did your child receive early intervention? \_\_\_\_\_yes \_\_\_\_\_\_no

Does your child have an IEP? \_\_\_\_\_yes \_\_\_\_\_\_no

What services is your child currently receiving?

\_\_\_\_\_\_speech \_\_\_\_\_OT \_\_\_\_\_PT \_\_\_\_\_ myofunctional therapy \_\_\_\_\_counseling \_\_\_\_\_ ABA

Feel free to write additional details here:

**Medical History**

Does your child have (or had) any of the following issues?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Frequent colds or congestion |  | Bronchitis |
|  | Strep |  | Tongue/lip/cheek tie(s) |
|  | Middle ear infections |  | Asthma |
|  | Food allergies (list) |  | Other allergies (list) |
|  | Constipation |  | Reflux/GERD |
|  | Trouble sleeping |  | Diarrhea |
|  | Laryngomalacia |  | Malnutrition |
|  | Failure to thrive |  | Frequent spit up |
|  | Frequent or cyclic vomiting |  | Bed wetting |
|  | Feeding tube |  | Sleep apnea |
|  | Sleep issues |  | Snoring |
|  |  Other (please explain): |

Has your child had any surgeries? (please explain)

Has your child ever been on medication?

Is your child currently on medication?

**Dental History**

Has a dentist seen your child? \_\_\_\_yes \_\_\_\_no Orthodontist? \_\_\_\_yes \_\_\_\_no

Does the dentist have any concerns about structure? \_\_\_\_yes \_\_\_\_no

\_\_\_\_\_\_ high palate \_\_\_\_\_\_\_ crowding \_\_\_\_\_\_ spaces between the teeth \_\_\_\_\_\_ cavities

\_\_\_\_\_\_ teeth grinding/bruxism \_\_\_\_\_\_ tongue-tie \_\_\_\_\_\_ lip tie \_\_\_\_\_\_\_ plaque \_\_\_\_thrush

**Feeding History**

Was your baby breast or bottle fed?

Are there any concerns about nutritional status? \_\_\_\_yes \_\_\_\_no

Do you have any concerns about feeding safety? \_\_\_\_yes \_\_\_\_no

Has your child had a swallow study? (If so, please attach the results) \_\_\_\_yes \_\_\_\_no

Prior to birth, how did you plan to feed your baby? Breast\_\_\_\_ Bottle\_\_\_\_\_

How did you end up feeding the baby? Breast\_\_\_\_ Bottle\_\_\_\_\_

Did you seek assistance with breastfeeding? PCP\_\_\_\_\_ Lactation Consultant\_\_\_\_\_\_ SLP \_\_\_\_\_\_ OT\_\_\_\_\_\_\_\_ (if you have checked list off, please explain)

Did you child have any difficulty breastfeeding/bottle feeding?

\_\_\_\_\_Difficulty latching \_\_\_\_\_crying \_\_\_\_\_ gagging \_\_\_\_\_coughing \_\_\_\_\_reflux

\_\_\_\_dribbling \_\_\_\_\_\_\_\_\_ refusal Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did you introduce spoon feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child have any difficulty with smooth pureed food?

\_\_\_\_ coughing \_\_\_\_ gagging \_\_\_\_choking \_\_\_\_vomiting \_\_\_\_spitting out food \_\_\_\_food refusal

Chunky pureed food?

\_\_\_\_ coughing \_\_\_\_ gagging \_\_\_\_choking \_\_\_\_vomiting \_\_\_\_spitting out food \_\_\_\_food refusal

At what age did you introduce solid foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child have any difficulty with dissolvable solids (i.e.: cheerios, puffs)?

\_\_\_\_coughing \_\_\_\_gagging \_\_\_\_choking \_\_\_\_vomiting, \_\_\_\_spitting out \_\_\_\_\_ food refusal

Did your child have any difficulty with soft vegetables/fruits?

\_\_\_\_coughing \_\_\_\_gagging \_\_\_\_choking \_\_\_\_vomiting, \_\_\_\_spitting out \_\_\_\_\_ food refusal

Did your child have any difficulty with chicken/meats?

 \_\_\_\_coughing \_\_\_\_gagging \_\_\_\_choking \_\_\_\_vomiting, \_\_\_\_spitting out \_\_\_\_\_ food refusal

At what age did your child stop breast or bottle feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child have difficulty transitioning to a straw? \_\_\_\_\_ yes \_\_\_\_\_ no

Did your child have difficulty transitioning to a cup? \_\_\_\_\_ yes \_\_\_\_\_ no

Is your child on a special or restricted diet (i.e., gluten free, dairy free)? \_\_\_\_yes \_\_\_\_no

If so, please describe:

Does your child have a self- limited diet (picky eating)? \_\_\_\_yes \_\_\_\_no

If so, please describe:

Does your child have any food aversions? \_\_\_\_yes \_\_\_\_no

Please indicate difficulties with taste, texture, temperature, color, size and/or shape:

Are mealtimes longer than normal? \_\_\_\_yes \_\_\_\_no

Would your child prefer to graze rather than sit for a meal? \_\_\_\_yes \_\_\_\_no

Please chart what your child eats (item and amount), in the following *Five-Day Baseline Diet*:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 |
| Breakfast |  |  |  |  |  |
| Snack |  |  |  |  |  |
| Lunch |  |  |  |  |  |
| Snack |  |  |  |  |  |
| Dinner |  |  |  |  |  |
| snack |  |  |  |  |  |

**Sensory:**

Check off any sense that your child has challenges with:

Sight \_\_\_\_ sound \_\_\_\_\_ texture (cloth. sand etc.) \_\_\_\_\_taste \_\_\_\_\_ smell \_\_\_\_\_

Does your child engage in any self-stimulatory behaviors?

Flapping \_\_\_\_ scripting\_\_\_\_ vocalizing \_\_\_\_ lining up objects \_\_\_\_ repetitive actions\_\_\_\_

Toe walking \_\_\_\_ spinning \_\_\_\_ visual staring /looking sideways \_\_\_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional sensory information?

**Oral-Motor/Oral Habits:**

Has your child drooled excessively? \_\_\_\_yes \_\_\_\_no

 Did your child use a sippy cup for more than 3-6 months? \_\_\_\_yes \_\_\_\_no

Does your child currently use a sippy cup? \_\_\_\_\_\_\_ yes \_\_\_\_\_\_ no

Does your child suck his/her thumb or digits? \_\_\_\_yes \_\_\_\_no

Did your child use a pacifier? \_\_\_\_yes \_\_\_\_no If so, for how long?

Does your child currently use a pacifier? \_\_\_\_\_\_ yes \_\_\_\_\_\_ no

If yes how often?

Does your child exhibit open mouth posture and mouth breathing? \_\_\_\_yes \_\_\_\_no

**Speech**

Is your child’s speech intelligible to the familiar listener? \_\_\_\_<25% \_\_\_\_ 25-50% \_\_\_\_50-75% \_\_\_\_75>%

Is your child’s speech intelligible to the unfamiliar listener? \_\_\_\_<25% \_\_\_\_ 25-50% \_\_\_\_50-75% \_\_\_\_75>%

Does intelligibility change as your child moves from single words to sentences? \_\_\_\_ yes \_\_\_\_no

Do you have any concerns about sound production? \_\_\_\_ yes \_\_\_\_no

If yes, what sound (s) does your child have difficulty producing (circle sounds that apply)?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| B | M | P | W | T | D | N | L | K |
| G | H | R | Sh | Ch | J | S | Z | J |
| R blends | L blends | S blends | K blends | TH | VOWELS |  |  |  |

**Therapy**

Has a lactation specialist seen your child: \_\_\_\_ yes \_\_\_\_ no

\*Name of IBCLC:

Has your child been seen for feeding therapy? \_\_\_\_ yes \_\_\_\_ no

\*Name of treating therapist:

Has your child been seen for speech therapy? \_\_\_\_ yes \_\_\_\_ no

\*Name of treating therapist:

Has your child been seen for occupational therapy? \_\_\_\_ yes \_\_\_\_ no

\*Name of treating therapist:

Has your child been seen for orofacial myofunctional therapy? \_\_\_\_ yes \_\_\_\_ no

\*Name of treating therapist:

Has your child been seen for ABA? \_\_\_\_ yes \_\_\_\_ no

\*Name of treating therapist:

**Social History:**

Does your child have any behavioral challenges?

What does your child enjoy?

How does your child engage with others?

Use 3-5 words to describe your child:

ADDITIONAL INFORMATION: (feel free to provide additional reports).