Rehabilitation Services Department
Speech-Language Pathology Services

CASE HISTORY FORM

Name of Client ___________________________________________________________  
(Last name, First name)

DOB ________________ Phone ________________________ ______________________
(Home) (Cell)

BACKGROUND INFORMATION
Does your child have a diagnosis? _______________ If yes, please list: ______________________

Describe your child’s speech and/or language difficulties: _________________________________
___________________________________________________________________________________
___________________________________________________________________________________

What languages are spoken in the home? ____________________________________________

PREGNANCY, BIRTH AND DEVELOPMENTAL HISTORY
Were there complications during pregnancy or birth? ________ If yes, please explain:
___________________________________________________________________________________
___________________________________________________________________________________
Was your child born prematurely? ________ If yes, by how many weeks? _________________

At what age did the following occur?
Sat Alone: ___________________ Crawled: ___________________
Stood Alone: _________________ Walked Alone: ________________
Said First Word: _____________

Has your child demonstrated difficulty chewing food or swallowing liquid? ________________
If yes, please describe: ______________________________________________________________

Have you noticed unusual eating patterns of your child? _______________ If yes, please describe:
___________________________________________________________________________________

MEDICAL HISTORY
Is your child currently under medical treatment or on medication? _____________ If yes, explain:
___________________________________________________________________________________

Does your child have, or has he/she had any of the following conditions (please check):
Visual Difficulty _____ Hearing Difficulty _____ Ear Infections _____
Allergies _______ Seizures _______ Encephalitis _______
Impetigo _________ Measles __________ Mumps ______
Chicken Pox ________ Cleft Palate _______ Head injury_______
Meningitis__________ Other (not listed): ________________________

L15925  (05/18)
Has your child received a speech and/or language evaluation previously? _________________
If yes, list the following:
Date of Evaluation: ___________ Location:_______________ Results: ________________
___________________________________________________________________________________

Has your child received services from the following professionals? (please check)
Psychologist ___________ Speech-Language Pathologist_______
Audiologist ___________ Special Educator__________________
Neurologist ____________ Ear, Nose, & Throat Physician: _______

EDUCATIONAL HISTORY
What is the name of your child’s current child care, preschool or school program?
____________________________________________________________________________
Location:____________  Start date:____________   Current Grade level:____________

Does your child currently participate in any therapies (Speech, OT, PT)? _____If yes, please list:
Type of therapy __________   How often_______________   Reason for therapy____________
____________________________________________________________________________ ______

SUMMARY:
Name of person completing this form: ________________________________________
Relationship to child: ______________________________________________________
Date completed: __________________________________________________________

Please send or fax the following forms to Speech-Language Pathology Services, LPCH, before your child’s appointment:
  1. Completed Case History Form.
  2. A copy of your child’s current IFSP (Individual Family Service Plan), IEP (Individual Education Plan), or other speech-language reports from outside clinics.

Thank you for taking the time to complete this form. It is an important part of the evaluation process and helps us to provide the appropriate evaluation for your child.

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