Lucile Packard Children’s Hospital at Stanford
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): __________________________
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.

Lucile Packard Children’s Hospital at Stanford
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