Janine Stiene Speech Language Pathology, P.C.

Main Office Phone: 631-689-6858 Fax: 631-751-6027

Case History

Prenatal History		
Duration of Pregnancy:	Length of Delivery:	Type of Delivery:
Any trauma, illness, condition, or accident during pregnancy or delivery? (if yes, explain):		
Any loss of oxygen to child during delivery? (if yes, how long):		

Immediately Following Birth	Yes	No
Blueish appearance		
Bruising		
Jaundice appearance		
Spent time in NICU		
Difficulty latching		
Difficulty sucking		
Difficult swallowing		
Consult w/ lactation specialist		
Difficulty w/ lactose formula		
Gassy		
Colic		
Spit up often		
Reflux		
Trialed a variety of formulas		
Trialed a variety of bottle types		
Trialed a variety of nipple types		
Trialed a variety of pacifier types		
Swallow Meconium		
Need to be aspirated		

Developmental History	Late	Early	Average	Never
Hold head up				
Roll Over				
Sit up (no support)				
Crawl				
Walk unaided				
Babble				
Speak 1st word				
Use Sentences				

Feeding History	Yes	No	Age started/discont'd
Breast Fed			
Bottle Fed			
Difficulties with baby cereal			
Difficulties with baby food			
Difficulties with Stage 1 foods			
Difficulties with Stage 2 foods			
Difficulties with Stage 3 foods			
Difficulties with finger foods			
Texture/consistency aversion			

Oral Motor/Motor Planning Skills	Y/N
Do you notice saliva on pillowcase?	
Do you notice saliva when awake?	
Do you notice saliva while speaking?	
Do you notice saliva while eating?	

Family History	
Has anyone in the family ever:	**Y/N**
Received speech therapy	
Received myofunctional therapy	
Had braces	
Had palate expander	
Suffered from TMJ/TMJ symptoms	
Suffered from sleep apnea	

Does your child:	Y/N	Does your child:	Y/N
Eat steak		Eat slow	
Eat yogurt w/ pieces		Drink excessively at meals	
Eat sandwhiches		Take oversized bites	
Eat soup		Over stuff	
Eat pasta sauce		Gag easily	
Eat condiments		Chew excessively	
Eat mashed potatoes		Spit out food	
Eat apple sauce		Ever choke	
Eat deli meat			
Eat eggs			
Eat hard foods			
Eat soft foods			
Eat crunchy foods			
Eat chewy foods			

Janine Stiene Speech Language Pathology, P.C.

Main Office Phone: 631-689-6858 ~ Fax: 631-751-6027

Background History						
Problem	**Y/N**	**How often/when/why:**	**Does your child:**	**Currently**	**Past**	**Never**
Ear infections			Grind their teeth			
Myringotomy tubes			Clench their teeth			
Strep throat			Have TMJ pain			
Tonsillitis			Snore			
Tonsillectomy			Move around a lot while asleep			
Adenoidectomy			Suck their thumb			
Bronchitis			Suck their finger			
Pneumonia			Suck their tongue			
Croup			Suck on their shirt			
Asthma			Lick their lips			
Use a nebulizer			Bite their lips			
Sinus infections			Have chapped lips			
Allergies						

Is there any additional information which you feel would better help us to understand your child?

_____

Did your child ever receive early intervention, preschool, or special education services to support their development? (Please explain)_____

Does your child seem to have any difficulty understanding speech sounds? If yes, please explain._____

At what age did your child start school?_____ Were any grades repeated?_____

Are there any school subjects with which they have particular difficulties?_____

How does your child get along with others?_____

Other Examinations

Has your child ever had a speech/language/processing evaluation or therapy prior to this time?_____

If yes, when and where? _____ Would you mind sharing these results?_____

Has your child ever received a full audiological evaluation? _____ If yes, when?_____

Why was it recommended and would you share the results?_____

Has your child ever had a full neurological and/or psychological evaluation?_____ If yes, when?_____

Who performed the evaluation and why and would you share the results?_____

Motor Function

Does your child have any sensitivity to different textures on their hands/face/feet/other body parts? If yes, please explain._____

Does your child have any difficulty manipulating their body in space? If yes, please explain.

_____

Does your child have difficulty manipulation small objects with their hands? _____

Does your child appear to have an awkward gate? _____

Does your child use their hands/eyes for anything other than their typical functions? (flapping, staring, biting)_____