



6520 3<sup>rd</sup> Street Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

### Case History Form

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Child resides with: \_\_\_\_\_

Father's email address: \_\_\_\_\_

Mother's email address: \_\_\_\_\_

I do wish to allow email communication \_\_\_\_\_

I DO NOT wish to allow email communication \_\_\_\_\_

Child's School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

#### **Insurance Information**

Insured's Name (if different from patient) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date of birth \_\_\_\_\_

Insurance: \_\_\_\_\_

Group# \_\_\_\_\_ ID or SS# \_\_\_\_\_

Insurance Phone \_\_\_\_\_

Referred by \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Dr. Address: \_\_\_\_\_ Phone \_\_\_\_\_

#### **Family History:**

Siblings: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_



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Is there a family history of : (Yes/No)

Speech/Language Difficulties \_\_\_\_\_

Hearing Impairment/Deafness \_\_\_\_\_

Learning Difficulties \_\_\_\_\_

If you responded "yes" to any of the above, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

If yes, which language? \_\_\_\_\_

Does the child speak this language? \_\_\_\_\_ Yes \_\_\_\_\_ No

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

**Birth and Medical History**

Was there anything unusual about the pregnancy or birth? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_

How old was the mother when the child was born? \_\_\_\_\_

How many months was the pregnancy? \_\_\_\_\_

Was the mother sick during pregnancy? \_\_\_\_\_

Birth weight? \_\_\_\_\_

Has your child had any of the following:

Adenoidectomy \_\_\_\_\_ High Fevers \_\_\_\_\_ Allergies \_\_\_\_\_

Head injury \_\_\_\_\_ Breathing Difficulties \_\_\_\_\_ Sleeping difficulties \_\_\_\_\_

Chicken Pox \_\_\_\_\_ Thumb/Finger Sucking \_\_\_\_\_ Frequent Colds \_\_\_\_\_

Tonsillectomy \_\_\_\_\_ Frequent Ear Infections \_\_\_\_\_ Tonsillitis \_\_\_\_\_

Ear (PE) Tubes \_\_\_\_\_ Vision Problems \_\_\_\_\_

If you checked any, please provide details/dates: \_\_\_\_\_

\_\_\_\_\_



Other serious illness/injury: \_\_\_\_\_

Date of last hearing screening: \_\_\_\_\_ Results: \_\_\_\_\_

Date of last vision screening: \_\_\_\_\_ Results: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Medications: \_\_\_\_\_

**Developmental History**

Please tell the approximate age your child reached the following milestones:

\_\_\_\_\_ Sat Alone      \_\_\_\_\_ Grasped crayon/pencil      \_\_\_\_\_ Babbled  
\_\_\_\_\_ Crawled      \_\_\_\_\_ Said first word (s)      \_\_\_\_\_ Put two words together  
\_\_\_\_\_ Spoke in short sentences      \_\_\_\_\_ Walked  
\_\_\_\_\_ Completed toilet training

**Oral Motor & Feeding History:**

Has your child experienced feeding/eating difficulties (e.g. biting, swallowing, chewing)? Yes/No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Was your child breast-fed or bottle-fed? \_\_\_\_\_

Does your child eat by self using utensils? Yes/No \_\_\_\_\_ Drool? \_\_\_\_\_

Does your child put toys in mouth? Yes/No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Does your child have food allergies? Yes/No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Does your child have food preferences/aversions? Yes/No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**Speech & Language Development:**

How does your child prefer to communicate?

\_\_\_\_\_ gestures      \_\_\_\_\_ words      \_\_\_\_\_ both      \_\_\_\_\_ neither

Number of words in a typical sentence? \_\_\_\_\_



Is your child's speech difficult to understand? \_\_\_\_\_

What types of speech errors does he/she exhibit? \_\_\_\_\_

Does your child: identify objects? \_\_\_\_\_ actions? \_\_\_\_\_ ask questions? \_\_\_\_\_

Follow directions? \_\_\_\_\_ understand what you are saying? \_\_\_\_\_

Respond correctly to yes/no questions? \_\_\_\_\_

Respond correctly to "WH" (who, what, etc.) questions? \_\_\_\_\_

Please provide examples of your child's speech language: \_\_\_\_\_

Has your child ever received a speech/language evaluation? Yes/No \_\_\_\_\_ Date \_\_\_\_\_

Has your child received speech/language therapy previously? Yes/No \_\_\_\_\_

If yes, when? For how long? \_\_\_\_\_

Can your child have food for therapy and/or rewards? Yes/No \_\_\_\_\_

If yes, please list any exceptions: \_\_\_\_\_

Please indicate your current concerns: \_\_\_\_\_

Is your child aware of, or frustrated by, any speech/language difficulties? \_\_\_\_\_

What do you see as your child's most difficult problem in the home? \_\_\_\_\_

What do you see as your child's most difficult problem in school? \_\_\_\_\_

**School History**

Has your child ever repeated a grade? \_\_\_\_\_ If so, what grade? \_\_\_\_\_

What are your child's strengths and/or best subjects? \_\_\_\_\_

Is your child having difficulty with a particular subject? Yes/No \_\_\_\_\_ Subject \_\_\_\_\_

Is your child receiving help at school or at home (i.e., support services, tutoring, etc.)?

Yes/No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

**Favorite Activities**

Please list your child's favorite activities, hobbies, toys, games, etc. \_\_\_\_\_



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**PLEASE READ AND SIGN THE FOLLOWING**

I give permission for Taylor Made Therapies, LLC and contracted therapists to evaluate and treat my child.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed and received Taylor Made Therapies LLC's HIPAA Policy Statement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize release of any medical or other information necessary to process this claim, including release of information to my Primary Care Physician as designated above and directly to the insurance company. I authorize payment of medical benefits to Taylor Made Therapies, LLC for services provided. I request and assign benefits to Taylor Made Therapies, LLC for all insurance benefits otherwise payable to me for services rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize discussion of my case with the following specific individuals:

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

Signature \_\_\_\_\_ Date \_\_\_\_\_