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LSU Health Sciences Center

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CHILD'S CASE HISTORY FORM

Date: ___________________________

Child's Name ____ Sex ___________________

Birthdate______________________ Age _________

Address ____

City/State Zip Code

Parents Home Phone______________________ Work__________________ Cell___________________

Email address:

FAMILY INFORMATION

Parent's Name ____DOB_________________________

Birthplace____Highest Grade Completed in School ________

Occupation and place of employment____

Parent's Name ____DOB_________________________

Birthplace____Highest Grade Completed in School ________

Occupation and place of employment____

Referred by ___________________________________Address_______________________________

FINANCIALLY RESPONSIBLE PARTY

Name ____ Relationship to child______________________

Address ____

Employer ____Occupation________________________

MEDICAL INSURANCE

Name____Phone#_______________________

Contract No:_______________________________________Group No:_____________________________

Name ____Group No:_____________________________

Medicare/Medicaid No. ____

____

List all pregnancies in order (include patient and miscarriages)

Name	Sex	Age	Grade in school	Any Problems

If necessary, use an additional sheet of paper for children's names

Birth History

Did mother have any of the following (check all that apply)

□bleeding	□swelling	□high blood pressure	□low blood pressure	□convulsions	□toxemia
□x-rays	□smoking	□excessive weight gain	□excessive weight loss	□diabetes	□ drink alcohol
□asthma	□surgeries	□heart condition	□thyroid condition	□rubella	□accident
□kidney disease	□susbstance abuse	□Other	Add other conditions:		

Was pregnancy normal?_____________ Were there any illnesses during pregnancy________________

Specify

List medications during pregnancy____

Diet during pregnancy____

Did labor come before or after due date?_____________________ How early or late?_____________________

How long was labor?___________________________ Medication during labor?___________________________

Type of delivery___________________________________ What was the patients' birthweight?____________

Was delivery _____head first ______feet first Did the baby turn _______yellow ______blue

Was the baby sleepy?____

Did the baby have sucking or feeding difficulty?____

Did the baby have birth defects?____

Medical History

What serious illness or accident has the child had? ____

Does your child have any handicaps?___________ If yes, describe ___________________________________

____

Indicate the illness the patient has had and the age at the time he/she had them. Check all that apply

□ Measles ________ Age	□ Mumps ________ Age	□Chicken pox ________ Age	□ Frequent Colds________ Age	□ Allergies ________ Age	□ Speech difficulties ________ Age
□ Serious high fever ________	□Earache or draining ear ________ Age	□ Hearing difficulties ________ Age	□ Asthma ________ Age	□ Bed wetting ________ Age	□ Vomiting or headaches ________ Age
□ Meningitis ________ Age	□ Pneumonia ________ Age	□ Convulsions, spasms or seizures ________ Age	How many convulsions, spasms or seizures? ________	When was the last convulsions, spasms or seizures ________?	

Describe these medical problems
___

What medication is the child taking? ___
What surgery has the child had? ___ When?___
Has child had an EEG (Brain wave test)?___ When? ___ Where?___
Results___
Is the child in good health at this time?___ Does the child have a visual problem? ___
Describe___
Health of other family members
___

Developmental History (state age when the child first:)

	Fed self	**Toilet trained**	
Sat alone ___	spoon ___	day___	Rode tricycle ___
Walked alone ___	fork ___	night___	Rode bicycle ___

Speech, Language and Hearing History
List any speech or hearing problems on either side of the family ___
___
What have you been told is your child's main problem or diagnosis?___
What has been done about it?___
What do you expect of this visit? ___
What questions would you like answered from this evaluation? ___
During the first year did your child make much sound other than crying?___
What age did your child first say words? ___ What were they?___
Did your child keep adding words once he started to talk?___
What age did your child first start to talk?___What age did your child name most things?___
What age did your child combine words into small sentences like, "Want drink" or "Me cut"?___
What age did your child use more complete short sentences? ___
Did the speech learning ever seem to stop for a period?___ If so describe ___

What efforts have been made to help the child talk better?___
Has there been a change in your child's speech in the last six months?
Describe the change___
Was his/her speech ever better than it is now? ___
Has there been any change in the child's hearing in the last six months?___
___
Describe the change ___

Has either ear ever pained or ached?___
Is your child's hearing better on some days than others? ___

How does your child communicate with you? ____

Education

Name of the present school ______________________________ Address_________________________________

Previous schools attended:

Age entered_______Grade entered_______ Current grade ______ Teacher (s)______

School performance: ___Good ___Average ___Poor

Have you ever applied for services? ________ Are you currently receiving services (if yes, specify)

When ? ________________ Where? ____

Comments____

Social

Who lives in the home with your child? ____

What unusual fears does your child have? ____

How would you describe your child (circle): Leader Follower Active Nervous

Plays well with others Plays alone Shy Aggressive

Describe any behavioral problem(s)

____

____

Is your child	□ Left handed	□ Right handed	□ No hand preference

Other Information

(List name, address and date of services of physicians and/or other agencies)

Physicians or Agency Address Date Seen

____

Please give any other information you think would be helpful to us. ______________________________________

Name of the person completing this form____

Relationship to the child ____