



**Beckman and Associates**  
Case History Form



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

E-Mail: \_\_\_\_\_

Phone: \_\_\_\_\_ Best # to reach you on appt. date: \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Child lives with both parents? YES NO If no, with whom? \_\_\_\_\_

**STATEMENT OF PROBLEM**

Please state in your own words what do you think the child's problem is, and what you think might have caused it.

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

When did you first notice the problem?

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

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Other doctors (dentists/orthodontists/psychologists) that provide care to this child

Name	Specialty	City
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous evaluations (list): \_\_\_\_\_

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Diagnosis: \_\_\_\_\_ Made by: \_\_\_\_\_ When: \_\_\_\_\_

Has your child received any therapy to date (list): How long? By whom?

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Describe present problem: \_\_\_\_\_

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Who noted present problem? \_\_\_\_\_ When? \_\_\_\_\_

**PRENATAL/BIRTH HISTORY**

Full Term: YES NO If no, how many weeks? \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Delivery: Vaginal Cesarean Breech Feet First

Illnesses or accidents during pregnancy: \_\_\_\_\_

Medications used during pregnancy: \_\_\_\_\_

What was the length of the labor? \_\_\_\_\_ Mothers health during pregnancy? \_\_\_\_\_

Was labor induced or spontaneous? \_\_\_\_\_

If induced, length of time on Pitocin? \_\_\_\_\_

Was fetal distress noted? \_\_\_\_\_ Was oxygen required? \_\_\_\_\_

Did the child have problems breathing at birth? \_\_\_\_\_ Sucking? \_\_\_\_\_

Fed via breast, bottle or Non-Oral? \_\_\_\_\_

Any concerns that may have affected gestation /birth? (Respiratory, circulatory, gastrointestinal)

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**MEDICAL HISTORY**

Please check if your child had had any of the following (and if so, at what age):

- |                 |                |            |               |
|-----------------|----------------|------------|---------------|
| Seizures        | High fevers    | Measles    | Mumps         |
| Chicken Pox     | Whooping cough | Diphtheria | Croup         |
| Pneumonia       | Tonsillitis    | Meningitis | Encephalitis  |
| Rheumatic fever | Tuberculosis   | Sinusitis  | Chronic colds |
| Enlarged glands | Thyroid        | Asthma     | Heart trouble |
- HIV

Please explain any checked items here: \_\_\_\_\_

\_\_\_\_\_

Are immunizations current: \_\_\_\_\_

Has your child had any earaches/ear infections? Y N Please explain here:

\_\_\_\_\_

Allergies? (Describe) \_\_\_\_\_

Any constipation? \_\_\_\_\_ Is bowel flow/BM daily? YES NO

Any reflux/vomiting? \_\_\_\_\_

Any other serious or recurrent illnesses? \_\_\_\_\_

Any operations? \_\_\_\_\_

Any accidents? \_\_\_\_\_

Any medications? (Past) \_\_\_\_\_ (Present) \_\_\_\_\_

Vision Problems? \_\_\_\_\_

Hearing difficulties: \_\_\_\_\_

Has your child had a hearing test? \_\_\_\_\_ When? \_\_\_\_\_ By whom? \_\_\_\_\_

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Other Medical History?

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**DEVELOPMENTAL HISTORY**

Has your child had any feeding difficulties? Check each item that applies.

- Sucking or nursing                      Excessive length of time to drink bottle
- Regurgitation of liquids or solids through the nose                      Chocking and/or gagging
- Difficulty chewing or swallowing meats                      Drooling

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed)

- \_\_\_ sat up alone      \_\_\_ crawled      \_\_\_ walked      \_\_\_ make wants known
- \_\_\_ Attention span for self directed activities                      \_\_\_ eat cereal from spoon
- \_\_\_ Eat pureed fruits/veggies      \_\_\_ Eat pureed meats      \_\_\_ Eat raw fruits/vegetables
- \_\_\_ Used a straw                      \_\_\_ Used cup without lid

Does your child choke while eating?      YES      NO

If "yes", on what foods? \_\_\_\_\_

Is your child a picky eater?      YES      NO

If "yes", what foods does s/he prefer? \_\_\_\_\_

Does your child drool more than other children his/her age?      YES      NO

Does your child have difficulty gaining weight as an infant?      YES      NO

Did or does your child suck their thumb? \_\_\_\_\_

Does your child use a pacifier? \_\_\_\_\_ What type? \_\_\_\_\_



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**LANGUAGE DEVELOPMENT**

How well is your child understood by: (i.e., what percentage of the time?)

Mom: \_\_\_\_\_ Dad: \_\_\_\_\_ Unfamiliar Adults: \_\_\_\_\_

Has your child received speech treatment? \_\_\_\_\_ How long? \_\_\_\_\_ By whom? \_\_\_\_\_

Describe what is like to have a conversation with your child:

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

Language(s) spoken in home: \_\_\_\_\_

Which are spoken by the child? \_\_\_\_\_

Which are understood by the child? \_\_\_\_\_

Age when your child spoke first word: \_\_\_\_\_ combined words: \_\_\_\_\_ in sentences: \_\_\_\_\_

How many words can your child say? (List if fewer than fifteen)

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

Does your child have difficulty following directions? (Describe)

\_\_\_\_\_

Any speech or hearing problems in the immediate or extended family (explain)?

\_\_\_\_\_

<b>Age</b>	<b>Behavior</b>	<b>Age</b>	<b>Behavior</b>
_____	cooing, pleasure sounds	_____	Single words
_____	babbling (ba-ba,da-da)	_____	phrases (go bye-bye)
_____	Jargon (talking own special language)	_____	short sentences



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What is the primary method(s) your child uses for letting you know what s/he wants?

Looking at objects	pointing at objects	gestures
Crying	vocalizing/ grunting	physical manipulation
Single words	2-3 word combinations	sentences

Which of the following best describes your child's speech?

Easy to understand	Difficult for parents to understand
Difficult for others to understand	almost never understood by others
Different from other children of the same age	

Which of the following best describes your child's reaction to his/her speech?

Is easily frustrated when not understood	Has been teased about their speech
Does not seem aware of speech/communication problem	
Tries to say sounds or words more clearly when asked	
Is successful in saying sounds or words more clearly when s/he tries	

Does your child have difficulty producing certain sounds \_\_\_\_\_ Yes \_\_\_\_\_ No

If "yes", which ones? \_\_\_\_\_



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**PLAY BEHAVIORS**

Which of the following describes the type of play your child likes to engage in the most often?

- |                              |                       |                  |
|------------------------------|-----------------------|------------------|
| Putting toys in mouth        | banging toys together | throwing toys    |
| Shaking toys                 | pushing/pulling toys  |                  |
| Acting out familiar routines | role-playing          |                  |
| Games with rules             | rough and tumble play | looking at books |

What is the length of time your child can stay playing at one activity?

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What activity seems to hold your child's attention for the longest period of time?

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Which activities seem to hold your child's attention for the shortest period of time?

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**SCHOOL HISTORY**

<b>Educational Setting</b>	<b>Location/School</b>	<b>Teacher(s)</b>	<b>Special Services?</b>
Child Care Facility			
Early Childhood Classes			
Pre-School			
K-5			
Middle School (6 to 9)			

Current School and Grade: \_\_\_\_\_

Completed by: \_\_\_\_\_

(Sign your name)

Date: \_\_\_\_\_

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