RachelKirson
SPEECH LANGUAGE PATHOLOGIST

Date: _____

CASE HISTORY FORM

Child's Name _____

D.O.B. _____ **Age** _____

Filled out by_____

Mother/Father's name_____

Address _____

Phone Number _____ **Email**_____

Mother/Father's name _____

Phone Number _____ **Email**_____

Address (if different from first parent)

_____

School & Grade_____

Language(s)_____

Parental Concerns_____

_____

_____

_____

Referred by _____

www.rachelkirsonslp.com (973) 996-8030 rachel@rachelkirsonslp.com

Please put N/A *Not Applicable* for all questions that do not apply

Who is the primary caretaker of the child? (e.g. spends most of the day with, feeds child, spends time with after school, etc):

_____

_____

_____

Remarkable birth history, past surgeries, injuries, serious illnesses or hospitalizations:

_____

_____

_____

Previous Evaluations (Please list professional's name and date)

_____

_____

_____

Audiological Evaluation

Where	When	Results

Current Therapies

Type	Frequency	Provider/Place

FEEDING (Check all that apply)

Pacifier	
Bottle	
Straw	
Cup	
Hands	
Spoon	
Fork	

Does your child avoid any tastes, textures, or temperatures?

_____

_____

COMMUNICATION (Check all that apply)

Gestures	
Pointing	
Pulling/Grabbing	
Single Sounds (e.g. Ahh)	
Single Words	
Short Phrases	
Sentences	

If your child communicates using **single sounds and words**, please list those sounds and words below:

_____

_____

_____

_____

Describe your child

_____

_____

_____

Additional Information

_____

_____

_____

Please attach or email any previous and/or recent evaluations (e.g. Early Intervention, CPSE, CSE, Neuropsychological, Developmental Pediatrician) from other professionals to rachel@rachelkirsonslp.com .

Mailing Address

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Contact Information

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