0-21 Evaluation Case History Form

Name:	Date of Birth:
Address:	Home: Cell:
Referral Source:	Email:
Mother's Name/Age/Occupation	Father's Name/Age/Occupation
Whole lives in the home?	Pediatrician name and address:
School Placement/Early Intervention Info:	Dentist name and address:
Languages Spoken:	Family History Medical/Educational:

Briefly, what is the reason(s) for this evaluation?

Birth History (please provide details where applicable)

Were there any complications during pregnancy? ____yes ____no (if yes explain)

Did you carry your baby full term? ____yes ____no (if no explain)

Were there problems during delivery? ____yes ____no (if yes explain)

Did your baby require any special care after delivery? ____yes ____no (if yes please explain)

Please indicate your child's:

birth weight _____ length/ height _____ Apgar score _____

Percentile of weight _____ Percentile of length/height _____

Developmental History:

At what age did your child……

Roll over	
Sit up	
crawl	
walk	
First vocalize	
Self-feed	
Say first word	
Say 2–3-word phrases	
Talk in sentences	
Toilet train	
Attend school	

Are there developmental concerns? _____yes _____no

Does your child have a global diagnosis (Down syndrome, autism etc.) ? _____yes _____no

If yes, please explain:

Does/did your child receive early intervention? _____yes _____no

Does your child have an IEP? _____yes _____no

What services is your child currently receiving?

_____speech _____OT _____PT _____ myofunctional therapy _____counseling _____ ABA

Feel free to write additional details here:

Medical History

Does your child have (or had) any of the following issues?

	Frequent colds		Bronchitis
	Strep		Congestion
	Middle ear infections		Asthma
	Food allergies (list)		Other allergies (list)
	Constipation		Reflux
	GERD/reflux		Diarrhea
	Laryngomalacia		Malnutrition
	Failure to thrive		Frequent spit up
	Frequent or cyclic vomiting		Bed wetting
	Feeding tube		Sleep apnea
	Sleep issues		Snoring
	Other (please explain):		

Has your child had any surgeries? (please explain)

Has your child ever been on medication?

Is your child currently on medication?

Dental History

Has your child been seen by a dentist? ____yes ____no Orthodontist ? ____yes ____no

Does the dentist have any concerns about structure? ____yes ____no

_____ high palate _____ crowding _____ spaces between the teeth _____ cavities

_____ teeth grinding/bruxism _____ tongue-tie _____ lip tie _____ plaque ____thrush

Feeding History

Was your baby breast or bottle fed?

Are there any concerns about nutritional status? ____yes ____no

Do you have any concerns about feeding safety? ____yes ____no

Has your child had a swallow study? (If so please attach the results) ____yes ____no

Prior to birth, how did you plan to feed your baby? Breast____ Bottle_____

How did you end up feeding the baby? Breast____ Bottle_____

Did you seek assistance with breastfeeding? PCP_____ Lactation Consultant_____ SLP _____ OT_____ (if you have checked list off please explain)

Was a lip, cheek or tongue tie identified? ____yes ____no

Did you child have any difficulty breastfeeding/bottle feeding?

_____Difficulty latching _____crying _____ gagging _____coughing _____reflux

____dribbling _____ refusal Other: _____

At what age did you introduce spoon feeding? _____

Did your child have any difficulty with smooth pureed food?

____ coughing ____ gagging ____choking ____vomiting ____spitting out food ____food refusal

Chunky pureed food?

____ coughing ____ gagging ____choking ____vomiting ____spitting out food ____food refusal

At what age did you introduce solid foods? _____

Did your child have any difficulty with dissolvable solids (i.e.: cheerios, puffs)?

____coughing ____gagging ____choking ____vomiting, ____spitting out _____ food refusal

Did your child have any difficulty with soft vegetables/fruits?

____coughing ____gagging ____choking ____vomiting, ____spitting out _____ food refusal

Did your child have any difficulty with chicken/meats?

____coughing ____gagging ____choking ____vomiting, ____spitting out _____ food refusal

At what age did your child stop breast or bottle feeding? _____

Did your child have difficulty transitioning to a straw? _____ yes _____ no

Did your child have difficulty transitioning to a cup? _____ yes _____ no

Is your child on a special or restricted diet (i.e., gluten free, dairy free)? ____yes ____no

If so, please describe:

Does your child have a self- limited diet (picky eating) ? ____yes ____no

If so, please describe:

Does your child have any food aversions? ____yes ____no

Please indicate difficulties with taste, texture, temperature, color, size and/or shape:

Are mealtimes longer than normal? ____yes ____no

Would your child prefer to graze rather than sit for a meal? ____yes ____no

Please chart what your child eats (item and amount), in the following *Five Day Baseline Diet*:

	Day 1	Day 2	Day 3	Day 4	Day 5
Breakfast					
Snack					
Lunch					
Snack					
Dinner					
snack					

Sensory:

Check off any sense that your child has challenges with:

Sight ____ sound _____ texture (cloth. sand etc.) _____taste _____ smell _____

Does your child engage in any self-stimulatory behaviors?

Flapping ____ scripting____ vocalizing ____ lining up objects ____ repetitive actions____

Toe walking ____ spinning ____ visual staring /looking sideways ____ other _____

Any additional sensory information?

Oral-Motor/Oral Habits:

Has your child had excessive drooling? ____yes ____no

Did your child use a sippy cup for more than 3-6 months? ____yes ____no

Does your child currently use a sippy cup? _____ yes _____ no

Does your child suck his/her thumb or digits? ____yes ____no

Did your child use a pacifier? ____yes ____no If so, for how long?

Does your child currently use a pacifier? _____ yes _____ no

If yes how often?

Does your child exhibit open mouth posture and mouth breathing? ____yes ____no

Speech

Is your child's speech intelligible to the familiar listener? ____<25% ____ 25-50% ____50-75% ____75>%

Is your child's speech intelligible to the unfamiliar listener? ____<25% ____ 25-50% ____50-75% ____75>%

Does intelligibility change as your child moves from single words to sentences? ____ yes ____no

Do you have any concerns about sound production?____ yes ____no

If yes, what sound(s) does your child have difficulty producing (circle sounds that apply)?

B	M	P	W	T	D	N	L	K
G	H	R	Sh	Ch	J	S	Z	J
R blends	L blends	S blends	K blends	TH	VOWELS			

Therapy

Has your child been seen by a lactation specialist: ____ yes ____ no

*Name of IBCLC:

Has your child been seen for feeding therapy? ____ yes ____ no

*Name of treating therapist:

Has your child been seen for speech therapy? ____ yes ____ no

*Name of treating therapist:

Has your child been seen for occupational therapy? ____ yes ____ no

*Name of treating therapist:

Social History:

What does your child enjoy?

How does your child engage with others?

Use 3-5 words to describe your child:

ADDITIONAL INFORMATION: (feel free to provide additional reports).