Health PEI
One Island Health System
Speech Language Pathology
161 St. Peter's Road
PO Box 2000
Charlottetown, PE C1A 7N8
T: 1-844-344-TALK (8255) / F:902-620-3195
speechandhearing@ihis.org

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Un système de santé unique
Orthophonie
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Île-du-Prince-Édouard, C1A 7N8
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Paediatric Speech and Language Pathology Case History

"All about your child . . ."

BASIC INFORMATION

Name: _____ Birthdate: _____
Family Physician: _____ Age: _____ Gender: ☐ M ☐ F
Mother's Name: _____
Address: _____
_____
Email: _____
Telephone: Work: _____ Cell: _____ Daytime: _____
Father's Name: _____
Address: _____
_____
Email: _____
Telephone: Work: _____ Cell: _____ Daytime: _____

Does your child participate in any of the following? If so, please specify:
☐ Day Care _____ ☐ Preschool Program _____
☐ Community Program (e.g. gym, swim, library, etc.) _____

Language(s) used in the home: ☐ English ☐ French ☐ Other _____
(please circle and identify language most spoken at home)

Was your child born in Canada? ☐ Yes ☐ No

Describe any concerns you have about your child:_____
_____
_____

FAMILY BACKGROUND

1. Who is currently living in your home?

Name	Relationship	Age (children only)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Is there a family history of speech, language or hearing difficulties? _____
_____
- difficulties in school? _____
_____

PREGNANCY AND BIRTH HISTORY (Please check appropriate box)

During your pregnancy did you have	Yes	No	If "yes", please specify
Any illness or accidents?	☐	☐	_____
Any drugs (prescription or non-prescription), alcohol, or tobacco use?	☐	☐	_____
Any difficulty at time of birth?	☐	☐	_____

Length of pregnancy (months) _____

Child's birth weight: ____ lbs ____ oz

DEVELOPMENTAL HISTORY

How old was your child when he/she did the following:

sat alone? _____ walked alone? _____

said first words? _____ put two or more words together? _____

was toilet trained? _____

MEDICAL HISTORY

1. Has your child had any of the following? (Please check all that apply)

☐ Tonsils / adenoids removed	☐ Snoring / mouth breathing	☐ Vision problem
☐ Frequent ear infections / colds	☐ Sleeping difficult	☐ Nursing/ feeding difficulties
☐ Allergies / analphylaxis	☐ High fevers	☐ Unusual eating habits
☐ Middle ear tubes	☐ Seizures	☐ Thumb/finger sucking habits
☐ Hearing problem	☐ Head injury	☐ Surgery
☐ Asthma	☐ Serious illness / accident	☐ Other: _____

2. Does your child take any medications? If so, please list. _____

_____

3. Has your child been seen by:	Yes	No	If "yes", please name
Speech language pathologist	☐	☐	_____
Audiologist or had a hearing test	☐	☐	_____
Paediatrician	☐	☐	_____
Ear, Nose, Throat (ENT) doctor	☐	☐	_____
Best Start?	☐	☐	_____
Other services? (psychologist, occupational therapist, Triple P, etc.)	☐	☐	_____

SOCIAL AND EMOTIONAL DEVELOPMENT

1. Does your child have opportunities to play with other children? ☐ Yes ☐ No
   If so, how often and where? _____
2. Does your child play well with friends/brothers/sisters/cousins? ☐ Yes ☐ No
3. Does your child take turns during play? ☐ Yes ☐ No
4. Please describe activities that your child enjoys doing or playing? _____

_____

_____

_____

_____

5. Does your child adapt well to a new environment? ☐ Yes ☐ No
6. Please check any that apply to your child:

☐ Cooperative	☐ Easily frustrated	☐ Poor eye contact
☐ Attentive	☐ Impulsive	☐ Behavior difficult to manage
☐ Friendly/outgoing	☐ Prefers to play alone	☐ Temper tantrums
☐ Shy/quiet	☐ Aggressive at times	☐ Unusual interests

SPEECH / LANGUAGE DEVELOPMENT

1. How does your child communicate most of the time? (Check all that apply)
   - ☐ gestures (e.g., pointing, pulling parents)
   - ☐ sounds (e.g., grunting, speech sounds)
   - ☐ single words (e.g., mine, shoe)
   - ☐ 2-3 word combinations (e.g., want cookie, mommy car)
   - ☐ sentences (e.g., I want my kitty, Where is my ball?)

2. You understand what your child says:
   ☐ all of the time ☐ most of the time ☐ some of the time ☐ rarely

3. People who don't know your child well understand your child's speech:
   ☐ all of the time ☐ most of the time ☐ some of the time ☐ rarely

4. Does your child say fewer words than he or she used to say? ☐ Yes ☐ No

5. When you are talking to your child, he or she understands what you are saying:
   ☐ all of the time ☐ most of the time ☐ some of the time ☐ rarely

6. Does your child follow simple directions? ☐ Yes ☐ No

7. Does your child answer simple questions? ☐ Yes ☐ No

Can you give examples of some words and/or sentences your child says?

_____
_____
_____
_____
_____

What else would you like to share with us about your child's development (i.e., your goals for your child, and any other information you think would be helpful in supporting you and your child)?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Form completed by: _____ Date: _____

Please return your completed case history form to:

Speech Language Pathology
161 St. Peters Road, PO Box 2000, Charlottetown, PE C1A 7N8
Fax: (902) 620-3195 | Email: speechandhearing@ihis.org

Thank you! We look forward to meeting you and your child soon!