Mary K. Chapman Center
Communicative Disorders Department
Cleft Palate Case History

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Parent/Guardian Name(s): _____

Address: _____ City/State/Zip: _____

Phone: _____ Email: _____

Referred By: _____ Referral Phone: _____

Insurance: _____ Policy Number: _____

Presenting Complaint(s): _____

_____

_____

Is there a history of any of the following? If yes, please explain below.

___ tube feeding	___ poor weight gain	___ high fevers
___ respiratory disease	___ allergies	___ ear infections
___ bradycardia monitor	___ pneumonia	___ abuse
___ physical handicaps	___ apnea monitor	___ speech/language delay
___ thumb/finger sucking	___ mouth breathing	___ bronchitis
___ frequent colds	___ tubes in ear(s)	___ apnea
___ failure to thrive	___ asthma	___ difficulty sleeping
___ sleep studies	___ snoring	___ behavior problems

Additional Comments: _____

_____

Has your child the following prior evaluations/treatment:

Speech/Language evaluation? _____ By whom and when? _____
Hearing evaluation? _____ By whom and when? ? _____
Psychological evaluation? _____ By whom and when? _____
Educational evaluation? _____ By whom and when? _____
Results? _____

Primary language spoken at home? _____

Primary language spoken by child? _____

How does your child respond to spoken directions or questions?

_____

Has your child ever worn a hearing aid? _____ If so, what type? _____
How long? _____ Does your child's hearing seem to fluctuate? _____

How does your child respond in the presence of background noise? _____

_____

Patient's Physician:_____ Specialty: _____

Condition(s) being treated (date and describe): _____

_____

Medications currently being taken (Name and Reason): _____

_____

Patient's dentist? _____ last seen: _____

Patient's orthodontist: _____ last seen: _____

Patient's oral and maxillofacial surgeon: _____ last seen: _____
Surgeries done so far (who, date, describe): _____

_____

Patient's ENT physician: _____ Date last seen: _____
Patient's speech-language pathologist: _____ Date last seen: _____
Treatment emphasis: _____
Is there any other information you feel would help us in evaluation of this patient?

_____

_____

_____

_____