CLARION UNIVERSITY OF PA
SPEECH AND HEARING CLINIC

CASE HISTORY - CHILD

I. Identification

Child's Name ______________________ Today's Date ______________________

Date of Birth ____________ Present Age ______ Phone: ______________________

Address ____

Referred By ____

School District ________________ Current Grade level__ ________________

Person to contact in case of emergency: Name ______________ Phone ______________

Physician ______________________ Address ______________________

Father's Name ______________ Age _____ Mother's Name ______________ Age ____

Occupation ______________________ Occupation ______________________

Siblings: Name ______________ Age ____ Name ____________ Age__________

Name ______________ Age ____ Name ____________ Age __________

If both parents are employed, who cares for your child?

Name ______________________ Phone ______________________

How would you describe the communication problem? ______________________

What are your concerns? ______________________

II. Birth History

A. Pregnancy

1. Was baby full term? Yes_____ No _____
2. Were there any complications during this pregnancy? Yes _____ No _____

   If yes, please describe ______________________

3. List any medications taken during this pregnancy ______________________

B. 1. Delivery (check one)

Natural Delivery _____ Cesarean Delivery _____
Difficult Delivery _____ Please describe ______________________

2. Any birth complications? Yes _____ No _____

   If yes, please describe ______________________

Neonatal Period (check one)

Normal Cyanotic (blue) Jaundiced Other:

Baby's birth weight ______________________

III. Developmental History

A. Motor Development

1. How old was your child when she/he first: sat supported ______________; crawled ________________;

   walked _________; fed self ______________; toilet trained - bladder _________, bowel ___________.

2. Does your child fall often? ____

3. Is your child well coordinated? Yes _____ No _____

4. Do you have any concerns about your child's motor development? Yes _____ No _____

   If yes, please describe your concerns. ____

   ____

5. Is your child: right handed _____ left handed _____ both _____

B. Speech and Language Development

1. How old was your child when her/she first:

   babbled ______; spoke first word________; combined 2 words _________; spoke in sentences ___________.

2. Did speech and language development seem to progress normally and then stop or regress?

   Yes _____ No _____ If yes, please describe ____

3. Does your child understand what is said to him/her? Yes _____ No _____

4. Does your child communicate with: (check any that apply)

   _____gestures _____ single words _____jargon _____phrases _____speak too fast

   _____speak to loudly _____ sound hoarse _____ sound nasal

5. Does your child: (check any that apply)

   _____mispronounce words _____hesitate or repeat sounds and words _____speak too fast

   _____speak too loudly _____ sound hoarse _____ sound nasal

6. Please describe any concerns you have about your child's speech ______________________________

   ____

7. Has your child's speech/language been tested before? If yes, Please give date, location and results:

   ____

   ____

8. Did your child receive any therapy services as a result of this testing? _____Yes _____No

9. Does your child currently receive speech/language therapy from another source? _____ Yes _____No

If yes, please list name and address of this source ______________________________

____

10. Is there a family history of speech, language, hearing or learning difficulties? _____Yes _____No

If yes, please list relationship to child and type of difficulties experienced ______________________________

____

Hearing Development

1. Does your child respond to: soft sounds? _____ Yes _____No environmental sounds? (i.e. doorbell, telephone, car horn) _____ Yes _____No people voices? _____Yes _____ No

2. Is your child easily distracted by background noises? _____Yes _____No

3. Can your child locate where a sound comes from? _____Yes _____No

4. Does your child follow directions as you would expect him/her to? _____Yes _____No

5. Does your child complain of noises in the ears? _____Yes _____No

6. Does your child frequently turn the volume up on radios, TV's , stereos? _____Yes _____No

7. Does your child complain of dizziness? _____Yes _____No

8. Does your child have any of the following (circle any that apply): excessive wax build-up, drainage from the ear (s), odor from the ear (s), pain in the ear(s)

9. Has your child's hearing been tested recently? _____Yes _____No

If yes, please give date, location and results ______________________________

____

10. Please describe any concerns you have about your child's hearing ______________________________

____

11. Does your child wear hearing aids? _____Yes, How Long? _____ _____No

If yes, please give make and model of hearing aid ______________________________

IV. Medical History

A. Description of present health of child______________________________

B. Does your child have any type of medical diagnosis? _____Yes _____No

If yes, please list diagnosis ______________________________

C. Medications - Is your child on any medications? _____Yes _____No If yes, please list.

Medication name ____________________ Date __________________ Dosage__________________

Medication name ____________________ Date __________________ Dosage__________________

Medication name ____________________ Date __________________ Dosage__________________

D. Vision

1. Does your child wear corrective lenses? _____Yes _____No

2. Is your child color blind? _____Yes _____No

3. Is there a history of vision problems in your family? _____Yes _____No

   If yes, please describe ____

E. Childhood Illnesses

1. Please check illnesses that your child has had:

_____measles _____mumps _____chicken pox _____frequent colds _____tonsillitis

_____chronic cough _____influenza _____bronchitis _____pneumonia _____asthma

_____diabetes _____epilepsy _____febrile seizures _____meningitis

_____ear infections, how often? __________________

2. Does your child have a history of high fevers (101+)? _____Yes _____No

   If yes, how high were fevers? How treated? medication_____ _____PE tubes

3. Are your child's immunizations up to date? _____Yes _____No

4. Does your child have tonsils and adenoids? _____Yes _____No

5. Has your child suffered from any seizures injuries or accidents? _____Yes _____No

   If yes, please describe____

6. Is your child on any type of special or restricted diet? _____Yes _____No

   If yes, please describe____

7. Are there any known problems with your child's tongue, roof of mouth (palate), nose, throat or ears?
   _____Yes _____No If yes, please describe____

F. Surgeries

1. Has your child undergone any surgical procedures? _____Yes _____No

   If yes, please list:

Procedure	Doctor	Date	Location
____________	____________	____________	____________
____________	____________	____________	____________

2. Were there any complications to any of these surgical procedures? _____Yes _____No

   If yes, please describe ____

G. Allergies - Does your child have any allergies? _____Yes _____No

   If yes, please list____

H. Medical Testing

1. Has your child ever had a psychological evaluation? _____Yes _____No

   psychiatric evaluation? _____Yes _____No neurological examination? _____Yes _____No

2. If yes to any of the above, please complete the following:

Name of Testing	Date	Location	Examiner
____________	______	________	____________
____________	______	________	____________
____________	______	________	____________

I. Behavior - Do you experience any difficulties controlling your child's behavior? _____Yes _____No

   If yes, please describe____

V. **Education Services**

A. Present school ______________________________ Grade ______________

1. Please list subjects in which your child needs help______________________________

2. Does your child receive any special services? _____Yes _____No If yes, describe ____________

____

B. Other Services

Service	Program Name	Teacher/Therapist	Dates
Pediatrician/Physician			
Child Care Program			
Infant Learning Program			
Head Start			
Pre-School			
Counselors (behavioral or other)			
Public Health Nurse			
Occupational Therapist			
Physical Therapist			
Speech Therapist			
Caseworker			
Other			
Other			