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Child Case History

Child's Name ______________________ Date of birth __________ Age __________

Mother's Name ______________________ Employer ______________________

Father's Name ______________________ Employer ______________________

Sibling(s) Name & Age ______________________

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Name of person answering questionnaire: ______________________

Who referred your child to the center? ______________________

Primary concerns: speech/language ______________ hearing ______________

Why is your child coming for an evaluation at this time? ______________________

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Birth and Developmental information

Mother's health during pregnancy:

illness / injury [ ] yes [ ] no
severe morning sickness [ ] yes [ ] no
medication used [ ] yes [ ] no
List: ______________________

toxemia [ ] yes [ ] no
hospitalized [ ] yes [ ] no

Child's birth history:

normal [ ] yes [ ] no
caesarean [ ] yes [ ] no
breech [ ] yes [ ] no
forceps [ ] yes [ ] no

Postnatal history:

low birth weight/preemie [ ] yes [ ] no
jaundice [ ] yes [ ] no
feeding problems [ ] yes [ ] no
breathing problems [ ] yes [ ] no
high bilirubin [ ] yes [ ] no

Were you or the child's physician concerned about your child's health or development during infancy?
[ ] yes [ ] no if so, why? ______________________

At what age did your child: hold head up __________ sit alone __________ dress self __________

Medical history

Name of child's physician ______________________ Phone Number __________

Has your child been diagnosed with any other conditions? (i.e. ADD, ADHD, Autism, Cerebral Palsy, other syndromes? ______________________

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Does your child have food allergies? Yes or no If yes, explain ______________________

____

Please list all medications:

Medication Name	**Dosage**	**How Often?**	**What For?**

Check evaluations or therapy:	**yes**	**no**	**when**	**where**
hearing evaluation				
speech/language evaluation				
speech/language therapy				
reading therapy				
writing therapy				
vision test				
psychological/educational evaluation				
physical therapy				
occupational therapy				
Counseling				
Other				

Medical conditions or treatments your child has experienced:	**yes**	**no**	**age**
ear surgery			
ear tubes			
earaches			
frequent colds			
Tonsillitis			
Allergies			
tonsillectomy/adenoidectomy			
head injury			
high fever (above 104)			
Meningitis			
Encephalitis			
measles/mumps			
serious accident			
convulsions/seizures			
digestive problems			
other surgery			
Other			

Hearing history

Do you think your child hears normally? [ ] yes [ ] no [ ] not sure

Does your child have a known hearing loss? [ ] yes [ ] no

Have others in child's family (including aunts, uncles, cousins) had hearing problems before age 50?
[ ] yes [ ] no if so, please describe ______________________________

Is there any difference in appearance or function for your child's ear/nose/throat or any other body part?
[ ] yes [ ] no if so, please describe ______________________________

Does your child:	**yes**	**no**	**sometimes**
wear a hearing aid	[ ]	[ ]	[ ]
respond to soft sounds	[ ]	[ ]	[ ]
startle to sudden loud sounds	[ ]	[ ]	[ ]
turn TV loud	[ ]	[ ]	[ ]
turn in direction of sound	[ ]	[ ]	[ ]
pull or dig at ears	[ ]	[ ]	[ ]
watch your face when you talk	[ ]	[ ]	[ ]
seem inattentive at home or school	[ ]	[ ]	[ ]
have trouble following directions	[ ]	[ ]	[ ]
come when called from another room	[ ]	[ ]	[ ]
respond when you call his/her name	[ ]	[ ]	[ ]
misunderstand what people say	[ ]	[ ]	[ ]
complain of ear pain	[ ]	[ ]	[ ]
say "what?" or "huh?" frequently	[ ]	[ ]	[ ]

Speech/Language

Did your child make sounds (babble, coo) during his/her first six months? [ ] yes [ ] no

At what age did your child say first words? ____________ two word combinations? ____________

Give examples: ______________________________

Did speech/language development ever stop or slow down? [ ] yes [ ] no

Are there any other children in the family experiencing difficulty with speech and hearing problems?

yes or no If yes, explain______________________________

Do you have concerns for your child concerning:	**yes**	**no**
not talking	[ ]	[ ]
being misunderstood by strangers	[ ]	[ ]
stuttering	[ ]	[ ]
vocabulary	[ ]	[ ]
incomplete sentences	[ ]	[ ]
pronunciation	[ ]	[ ]
sentence length	[ ]	[ ]
voice too nasal	[ ]	[ ]
voice not nasal enough	[ ]	[ ]
hoarse voice	[ ]	[ ]
following directions	[ ]	[ ]

Behavior Information

Does your child:	**yes**	**no**

get along with other children	[ ]	[ ]
sleep well	[ ]	[ ]
eat well	[ ]	[ ]
cry often	[ ]	[ ]
chewing/swallowing difficulties	[ ]	[ ]
seem nervous	[ ]	[ ]
Have frequent tantrums	[ ]	[ ]
act destructively	[ ]	[ ]
Have poor coordination/clumsiness	[ ]	[ ]
drool	[ ]	[ ]
seem shy	[ ]	[ ]
Have short attention span	[ ]	[ ]
React to specific textures, smells, sounds, tastes	[ ]	[ ]

Academics

Does your child:	**yes**	**no**
Demonstrate interest in books	[ ]	[ ]
Attempt to write own name	[ ]	[ ]
Tell or retell stories heard	[ ]	[ ]

What school does your child attend? ______________________________ grade _____

Does your child receive speech therapy at school? yes or no

If yes, list speech Therapist Name____________________Phone number______________

Therapist E-mail____

Does your child have an IEP? Yes or no

If yes, indicate services (i.e. speech, reading, writing, or special behavior)________________

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