UNIVERSITY OF SPEECH, LANGUAGE AND HEARING CLINIC
A UNITED WAY FACILITY
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Please provide, to the best of your ability, the following information about your child. If a question is not applicable to your child, place an NA in the space provided. If you need more space to answer a particular question, you may wish to attach a separate sheet.

CHILD CASE HISTORY FORM

Name ____ Birthdate ________________ Sex of Child __________

Parents' Names: ____ ________________

Address ____________________________________ City ____________, State________Zip ________________

County ______________________________ Home Phone ____

Mother's Work Phone __________ ______Father's Work Phone ______________________________________

School______________________________ School District _______________________________ Grade ______

Teacher's Name ____

School Address_____________________________ City ____________, State________Zip: _______________

Languages spoken in the home__________________________________Primary Language _________________

Name of person completing this form ____

Relationship to child____

Physician's name:___________________________________ Physician's phone number:____________________

Who referred you to this clinic? ____

Description of the Problem____

____

____

Under what circumstances did the problem begin? ____

____

At what age did the problem begin?_____ What (if anything) seems to affect the severity of the problem_______

____

Has a diagnosis been made?_____________If so, what is it?__________________________________

____

Have any of the following labels been applied? Intellectual Disability ____Pervasive Developmental Delay____

Cerebral Palsy _____ Down Syndrome____ Chronic Middle Ear Infections______ Learning Disability___

Attention Deficit Disorder ____Attention Deficit Hyperactivity Disorder ____ Down Syndrome ____ Central

Auditory Processing____ Cleft Lip or Palate____ Emotional Disability____ Developmental Delay____ Autism____

SPEECH DEVELOPMENT

Did the child make sounds during infancy? ___________ At approximately what age? ________________________

With or without your talking to him/her? _________________ Age of first words ______________________________

Age at which child put two words together (Ex. "Want cookie.") ______ Age at which child put three words together _____________ (Ex. "Mommy go bye-bye.") ____________ Did the child talk little or much? ___________

Describe: ____

Any periods when the child quit talking ______________ Describe ____

____

Does the child have any trouble pronouncing words? __________ Does the child have difficulty understanding what is said? ________________ Does the child have difficulty expressing her/himself verbally? _______________

If yes, describe ____

Has there been previous speech/language testing? __________ If yes, by whom? _____________________________

When? ________________________ Where? ____

Results: ____

Has there been previous speech/language therapy? _________ If yes, by whom? _____________________________

When? ____________________________ Where? ____

Results: ____

Has any effort been made at home to correct the problem? _____________ If yes, by whom ___________________

____

What methods were used to correct the problem? ____

Have there been any relatives with speech/language problems? _______ If yes, please state relationship(s) and the problem(s) ____

BIRTH HISTORY

What was the health of the mother during pregnancy? ____

Any: Measles? __________ Falls? __________ Drugs taken? ____

Alcohol _____________ Rh Negative? _______ Number of previous pregnancies ____________________________

Number of living children ___________ Length of pregnancy with this child? ______________________________

Doctor who delivered this child? ____

Delivery: Difficult? ________ Easy? ____________ Injury? _____________ Length of labor ____________________

Breech birth? ____________________ C-section? _____________ APGAR Score? ___________________________

Name of child's pediatrician: ____

Pediatricians address ____Zip_______________

Infant's Status: Birth weight____________ Birth length _____________Shape of head ________________

Jaundiced?______________ Breast fed?_____________Colic? _______________________

Feeding problems? ____

____

MOTOR DEVELOPMENT

Age of holding head up?_________________ Age of sitting up?___________________________________

How did the child crawl (hands and Knees? Stomach? Forward? Backward?) Describe ____________________

____

Age of first steps alone___________________________ Describe Coordination _______________________

Which hand does the child use to: Write?________ Throw a ball_______ Eat? ________ Use tools? ________

Has child shifted from one hand to the other? ____

Are any relatives left-handed? _____________________ If yes, list and state relationships: _______________

____

MEDICAL HISTORY

Are there any serous medical problems? __________________ If so, list ______________________________

____

Has there been vision testing? __________ If so, by whom? ______________________________________

Is vision normal? ______ Are glasses worn? _____ If yes, how long since last examination?_______________

State the vision problem ____

At what age were glasses first prescribed?____

Any tendencies to print letters or numerals backwards? __________ If so, which one _____________________

Any tendencies to read words or numerals backwards____________ Is paper work neat? __________________

Has there been hearing testing? ________ If so, by whom? _____________Where _____________________

Results? ____

When was the last hearing examination? ____________ Was hearing normal?__________________________

If no, state the problem____

Are hearing aids worn?_____________ Right? _________ Left? ____________ Type? ____________________

Any earaches and/or infections?__________If yes, was medical treatment necessary?_______________________

Age(s) at which child experienced ear problem? _________ Date of last infection ? ________________________

What medication, if any was prescribed?____

Were Pressure Equalization (PE) tubes inserted?_________ If so, what date? _____________________________

To your knowledge, are the tubes still in place? ____

Has the child experienced seizures?__________ If yes, when? ______________________________________

Have medications been prescribed? ____________If so, list ____

Any fainting spells? _______________ If so, when?____

Any other pertinent medical information, (such as accidents, operations, allergies, etc.) ____________________

Age of bladder control during the day __________During the night _________ Time child goes to bed________

Time child gets up _________________________Any problems sleeping? ______________________________

SCHOOL HISTORY

Are there any problems in school?________If yes, check problem areas: Understanding what is said __________

Expressing self orally? _______ Reading?________ Writing?_________Spelling _______ Arithmetic ________

Paying attention? _________ Memory? _________ Athletics?_________ Getting along with peers __________

Others? ____

____

Type of class: Regular education? _________________ Special education?______________________________

If Special Education, what label was used to qualify child? (Ex. learning disabled)_________________________

Have teachers noticed problems?____________ If yes, what was indicated? ___________________________

Current grades ___________________ Estimate of child's reading level_______________________________

Any Resource help? ______Private tutoring ______________________Has child's school performance changed

over the years? __________If yes, how? ____

Has child repeated a grade? _________ If yes, which grade? __________ Why? _________________________

____

What are the child's best subjects?____

Worst subjects?____

Does the child have problems working independently?_______________Do other members of the family have

learning problems? __________ If yes, state relationship and problem___________________________________

____

SOCIAL AND HOME ENVIRONMENT

Child lives with (check one):

___ Birth Parents ___Foster Parents ___ Parent & Step Parent

___ Adoptive Parents ___ One Parent ___ Other: ______________________________

Child's race/ethnic group: ___ Caucasian, Non-Hispanic ___ Hispanic ___ African-American

____ Native American ____ Asian or Pacific Islander ___Other ______________

Parents: Age of mother ________ Education (highest level) _______ Present occupation ___________________

Age of father ______ Education (highest level) __________ Present occupation ___________________

Divorced__________ When? ______________ Separated? _________ When?___________________

Step or foster parents? ____

Siblings: Brothers: Ages ___________ Any problems? ____

Sisters: Ages ____________ Any problems? ____

Are there any other persons living in the home? ________ Please describe age and relationship of other persons.

____

Does your child have friends? Many?______________ A few___________Very few ____________________

Does your child mostly socialize with children: his own age?__________Younger?________Older? __________

What is the child's attitude toward the speech problem? ____

____

____

What is the attitude of the family, friends, and relatives towards the child's speech problems? ________________

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Child's favorite activities: ____

ADDITIONAL QUESTIONS OR COMMENTS:

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