Bloomsburg University

Bloomsburg, Pennsylvania

DEPARTMENT OF AUDIOLOGY AND SPEECH PATHOLOGY
Speech, Hearing, and Language Clinic

CHILD AUDIOLOGIC CASE HISTORY FORM

Please complete this form and return it to the Speech, Hearing, and Language Clinic as soon as possible. This information will assist the staff in planning for and conducting a more meaningful evaluation.

Please answer the questions as fully and accurately as possible. You may disregard any questions that do not pertain to you.

Child's Name:________________________________ Date: ____________________

Age: _______ Sex: ______ Date of Birth: __________ Phone:______________________

Address:____

____

Medical Insurance Provider: ________________________ Insurance Number: __________

Person completing this Form: ____

Relationship to Child: __________________________ Phone: ______________

Referred by: ____________________________________ Phone: ______________

Reason for Referral: ____

Primary Care Physician: __________________________ Phone: ______________

Physician Address: ____

Describe the problem. Include when it began, if/how it has changed, and how the child and others react to the problem. What do you think caused the problem?

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Has the child seen any other speech-language pathologists or any other specialists? ( )YES ( )NO

If so, please list type of specialist, name, date evaluated, and conclusions or suggestions. ______

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SPEECH AND LANGUAGE DEVELOPMENT:

Is vocabulary age- appropriate? ( )YES ( )NO

Is the child easily understood? ( )YES ( )NO

Does the child hesitate or repeat words? ( )YES ( )NO

Does the child "get stuck" when saying words? ( )YES ( )NO

Does the child pronounce sounds incorrectly? ( )YES ( )NO If yes, which sounds? __________

Average number of words per sentence ___________
Child's primary language _________________ Language spoken in home_________________
Other languages spoken by the child ____
Does the child use any other means of communication? ( )YES ( )NO
If yes, please describe____
Please indicate the child's age at the time of each milestone:
Coo/babble _____ First words _____ Combine words_____ Sentences_____ Questions _____
Does the child have any structural problems of the tongue, palate, nose, throat, or ears?
( )YES( )NO If yes, please describe ____
Does the child demonstrate an awareness of this problem? ( )YES ( )NO
If yes, please indicate how he/she reacts:____

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FAMILY HISTORY:

Father Name: ____________________ Age: _________ Date of Birth: ________________
Address: ____
Home Phone: ________________ Cell Phone: _______________ Work Phone: ____________
Is father: ( ) Living with family ( ) Deceased ( ) Divorced/ separated
Occupation: ____________________________ Education: _____________________________

Mother Name: ___________________ Age: __________ Date of Birth: ________________
Address: ____
Home Phone: ________________ Cell Phone: _______________ Work Phone: ____________
Is mother: ( ) Living with family ( ) Deceased ( ) Divorced/ separated
Occupation: ____________________________ Education: _____________________________

Sibling(s)

Name	Age	Speech, Hearing, or Medical Problems	School, Grade, & Performance

Have any family members (e.g. parent, uncles, cousins) ever had any speech, hearing, language, or learning difficulties? If so, please describe.

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BIRTH/DEVELOPMENTAL HISTORY:

Length of pregnancy? _______ Which pregnancy was the child? _______ Birth weight ______
Were there any prenatal or birth complications? ____
Please list the child's age for accomplishing the following:
Sitting unaided________ Crawling _______Walking unaided _______ Toilet training________
Feeding self_______ Dressing self ________

MEDICAL INFORMATION:

Is your child currently on medication? YES NO If yes, what is the name and reason for the medication?

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Does the child have any medical problems? ( )YES ( )NO
If yes, please describe ____
Has the child ever had any hospitalizations/surgeries? If so, please list dates and describe.

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Does the child require any assistive aids/equipment (e.g., wheelchair, walker, communication device)? ____

BEHAVIORAL INFORMATION:

Does the child exhibit any of the following behaviors:

( ) Easily frustrated
( ) Thumb sucking
( ) Attention problems
( ) Feeding problems as infant
( ) Shyness
( ) Tantrums
( ) Swallowing/chewing
( ) Repetitive movements
( ) Drooling
( ) Over-activity
( ) Poor eye contact
( ) Distractibility

Does the child interact well with adults and other children? If not, what behaviors does he/she exhibit?

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EDUCATIONAL BACKGROUND

School: ____ Present Grade: ______________
At what age did child start school? ____

Easy subjects: ________________________ Difficult subjects: ______________________
What are his/her usual grades? ____
Does the child receive special services? If yes, please describe.

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Does the child have an IEP or IFSP? ____
Please describe specific difficulties: ____

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AUDITORY HISTORY

At what age was the child sensitive to sounds in his/ her environment? ________________

Did he/she respond to loud sounds only? ____________________________________

Did he/she seem to ignore sounds? ____

Does the child prefer to use speech or gestures? ________________________________

Does the child bang his/her head or stomp his/ her foot? ( )YES ( )NO

Does the child yell or screech to attract attention? ( )YES ( )NO

Does the child show an alertness to gesture, facial expression, or movement? ( )YES ( )NO

Do you think the child hears adequately? ( )YES ( )NO If no, please describe.

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Does the child's hearing appear to be constant or does it vary? ( )YES ( )NO

Is his/her hearing poorer when he/she has a cold? ______________________________

Has the child ever had hearing testing? If so, when, and what were the results? __________

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Does the child have: Chronic colds _______ Earaches _______ Allergies _______

Draining ears _______ Ear Infections _________

Has the child ever been seen by an audiologist or ear specialist? ( )YES ( )NO

Does the child wear a hearing aid? ( )YES ( )NO ( ) Right ( ) Left ( )Both

How long has he/she worn hearing aids? ______________________________

Has the child had special training for any of the following?

Speech reading __________ Auditory training ______________ Speech training _________

Where did he/she receive training? ______________________________

Has the child ever received treatment in the past year at the Bloomsburg University Speech, Hearing, and Language Clinic? ______________________________

Is there any other information that you can provide that may be helpful in our evaluation of the child? ______________________________

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PLEASE RETURN THIS FORM TO:

BILLIE BOTSFORD, CENTENNIAL HALL

SPEECH, HEARING & LANGUAGE CLINIC

BLOOMSBURG UNIVERSITY

BLOOMSBURG, PA 17815