COMMUNICATION SCIENCES
& ORAL HEALTH
TEXAS WOMAN'S UNIVERSITY

# SPEECH-LANGUAGE-AUDIOLOGY
# CASE HISTORY
# FOR CHILDREN

In preparation for your child's hearing and/or speech evaluation/therapy, we would like you to provide us with the following information. This information will assist the clinic staff in planning for and conducting a more meaningful examination and/or therapy session. Please return this completed form as soon as possible so an appointment time can be finalized for your child.

Please answer the questions as fully and accurately as possible. Many parents have found the child's baby book helpful in remembering particular dates. If you are not sure of a particular date, write the date that you think is correct and put a question mark after it. Your family physician may also be able to provide you with some information.

All of the following information is for the **confidential** use of the Speech, Language and Hearing Clinic staff only.

Date: ______________________________

Person completing this form: ________________________________ ________________________
Name Relationship to child

## I. REFERRAL

Who referred your child to this clinic? ________________________________________________

Professional title and/or relationship to the child: ________________________________________

Address: ___________________________________________________________________________
Street City State Zip

Phone Number: ______________________________________________________________________

Which of the following evaluation(s)/and/or therapy are you interested in?

Audiology Evaluation ☐ Speech/Language Evaluation ☐

Both Evaluations ☐ Speech Therapy ☐

What are your concerns in the areas of hearing, speech and language? ______________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

II.

Child's Name:________________________________________ Age: __________

Date of Birth:____________________________________ Male ☐ Female ☐

Address: ________________________________ Phone: ____________________
Street

________________________________
City State Zip Code

Mother's Name: ______________________________________ Age:__________

Address:________________________________ Home Phone:________________
Street

________________________________ Cell Phone: __________________
City State Zip

Email Address: ____________________________________________________

Mother's Occupation:________________________Work Phone: __________________

Father's Name:________________________________________Age:____________

Address:________________________________ Home Phone:________________
Street

________________________________ Cell Phone: __________________
City State Zip

Email Address: ____________________________________________________

Father's Occupation:________________________Work Phone: __________________

Highest grade level completed by mother:______________By father: ______________

Are parents divorced? Yes ☐ No ☐ If yes, who has custody of the child? _________

If child isn't living with either biological or adoptive parent, who has legal guardianship?

______________________________ Relationship to child: __________________

Address:________________________________ Home Phone:________________
Street

________________________________ Cell Phone: __________________
City State Zip

If the parent(s) are employed outside the home, who cares for the child in their absence?_______

________________________________________________________________

Family physician:______________________________Phone: __________________

List Siblings | Age | Male/Female | Do they live in the home?

________________ ______ Yes ☐ No ☐

________________ ______ Yes ☐ No ☐

________________ ______ Yes ☐ No ☐

________________ ______ Yes ☐ No ☐

Does anyone in the family have speech or hearing problems? Yes ☐ No ☐

If yes, indicate the relationship to the child and explain the type of problem: ________________

________________________________________________

## III. BIRTH AND PRENATAL HISTORY

During this pregnancy, did mother experience any unusual illness, condition or accident, such as German Measles, false labor, RH incompatibility, etc.? Yes ☐ No ☐ If yes, please describe: ________________________________________________

________________________________________________

Length of pregnancy: ____________ Duration of labor: ____________ Birth weight: ____________

Condition at birth: Normal delivery ☐ Caesarean ☐ Breech birth ☐

Anesthetics: Yes ☐ No ☐ Forceps: Yes ☐ No ☐ Was infant blue? Yes ☐ No ☐

Jaundiced: Yes ☐ No ☐ Other unusual conditions? ________________________

________________________________________________

Conditions immediately following birth:

Did infant have: Feeding problems ☐ Scars or bruises ☐ Seizures ☐

Swallowing or sucking difficulties ☐ Was birth weight regained quickly: Yes ☐ No ☐

Other (please explain) ________________________________________________

________________________________________________

## IV. DEVELOPMENT

First hold head up alone with no assistance? ________________ First crawl? ________________

Sit alone without support? ________________________

Pull himself/herself up to a standing position? ________________ Walk unaided? ________________

Gain bowel control? ________________________ Bladder control? ________________________

Weight of your child at 6 months?________________________Present weight? _________

Present height?___________________Does your child prefer right or left hand? _______________

Does your child fall or lose balance easily? Yes ☐ No ☐ If yes, please explain: ______

_____________________________________________________________________________

Does your child have (check all that apply): Difficulty with balance? ☐ Fear of heights? ☐

Show fear if moved unexpectedly? ☐

Are there activities that involve fast movements and spinning that your child finds difficult? Please explain_______________________________________________________________________

_____________________________________________________________________________

Does your child like to go to Six Flags? Yes ☐ No ☐

Can your child ride a bike? Yes ☐ No ☐

Does your child seem awkward or uncoordinated? Yes ☐ No ☐

Does your child have difficulty chewing or swallowing? Yes ☐ No ☐

Describe any developmental difficulties?_________________________________________

Describe any academic difficulties: (reading, math, writing, spelling) _________________________

_____________________________________________________________________________

Additional comments:_________________________________________________________

_____________________________________________________________________________

## V. MEDICAL

Check disease(s) your child has had, giving age and degree of severity:

| Disease | √ | Age | Mild, Average, or Severe | Disease | √ | Age | Mild, Average, or Severe |
|---|---|---|---|---|---|---|---|
| Allergies | | | | Kidney Disease | | | |
| Asthma | | | | Measles | | | |
| Bronchitis | | | | Meningitis | | | |
| Chicken Pox | | | | Mumps | | | |
| Colds (frequent) | | | | Ear Infection | | | |
| Hay fever | | | | Pneumonia | | | |
| Headache (frequent) | | | | Scarlet Fever | | | |
| Heart Disease | | | | Seizures | | | |
| Influenza | | | | Tonsillitis | | | |

What are your child's usual grades? (Check one)

Excellent ☐ Above average ☐ Average ☐ Below average ☐

Failing ☐

What is your child's attitude toward:

School?______________________________________________

His/hers homework? ______________________________________

How does your child get along with others at school? _____________________

Does your child sleep well? Yes ☐ No ☐ Does your child eat well? Yes ☐ No ☐

VI. SOCIAL

What activities and games does your child enjoy?_____________________

Does your child tend to play alone or with other children? ________________

What are the ages of your child's playmates? ________________________

Does he/she show fear? Often ☐ Sometimes ☐ Rarely ☐

What does he/she fear? ______________________________________

Is he/she "nervous"? Yes ☐ No ☐

How does he/she show it? ____________________________________

Has he/she been harder to manage than other children? Yes ☐ No ☐

By whom and how is your child disciplined?___________________________

Is your child difficult to discipline? Yes ☐ No ☐ Explain: ______________

_______________________________________________________________

Please check the boxes which identify your child's behaviors:

| | | |
|---|---|---|
| ☐lying | ☐sluggishness | ☐tongue sucking |
| ☐begging | ☐boastfulness | ☐strong fears |
| ☐stealing | ☐showing off | ☐strong hates |
| ☐smoking | ☐disobedience | ☐shyness |
| ☐rudeness | ☐destructiveness | ☐worrying |
| ☐swearing | ☐temper displays | ☐sensitivity |
| ☐fighting | ☐acts of violence | ☐easily depressed |

- ☐ jealousness
- ☐ selfishness
- ☐ excitability
- ☐ skipping school
- ☐ nose picking
- ☐ sleeplessness
- ☐ nightmares
- ☐ constipation
- ☐ mouth breathing
- ☐ night terrors
- ☐ quarrelsome behavior
- ☐ day-dreaming
- ☐ thumb sucking
- ☐ nail biting
- ☐ sex misbehavior
- ☐ convulsive behavior
- ☐ sleepwalking
- ☐ fainting
- ☐ face twitching
- ☐ easily discouraged
- ☐ suicidal inclinations
- ☐ running away from home
- ☐ associate w/bad company
- ☐ prefers younger children
- ☐ prefers older children
- ☐ snoring
- ☐ bed wetting
- ☐ complains of pain

Are there any indications of your child not hearing plainly? Yes ☐ No ☐

Discuss any of the above items in more detail if you think they would shed light on the problem:

______________________________________________________________________________

______________________________________________________________________________

## VII. SPEECH AND HEARING HISTORY

During your child's first 6 months, did he/she coo and babble? Yes ☐ No ☐

During the first year, did he/she make many sounds other than crying? Yes ☐ No ☐

Other than crying, would you say your child was:

☐ A silent baby? ☐ An average baby? ☐ A very noisy baby?

At what age did your child first day meaningful words? ______________________________

What were they? ______________________________________________________________

Did your child: ☐ say one or two words then go for a long time before saying other words?
Or ☐ continuously add words once he/she started to talk?

At what age did your child begin to name people and objects? ________________________

At what age did your child have a name for everything? ______________________________

______________________________________________________________________________
At what age did your child combine words into small sentences like, "want drink" or "me out"?

At what age did your child combine short sentences? ________________________________

Do you think your child has been slow in learning to talk? Yes ☐ No ☐

Does your child understand what you say as well as you think he/she should? Yes ☐ No ☐

If no, please explain: __________________________________________________________

Does your child verbalize now? Yes☐ No ☐ if no, how does he/she make requests?

At this time does your child talk:

☐ a great deal? ☐ an average amount? ☐ very little?

Does your child's talking consist mainly of:

☐ complete sentences? ☐ phrases? ☐ one or two words? ☐ sounds?

How well can your child be understood by brothers, sisters, playmates?

☐ good ☐ sometimes ☐ not at all

Comments:______________________________

How well can your child be understood by adults other than family members?

☐ good ☐ sometimes ☐ not at all

Comments:______________________________

Did speech learning ever seem to stop for a period? Yes ☐ No ☐

If "yes", please describe:______________________________

______________________________

Has your child ever communicated better than they do now? Yes ☐ No ☐

If "yes", please explain: ______________________________

______________________________

## XI. OTHER INFORMATION

If you suspect that your child has a hearing problem, when, why and by whom was the hearing problem first noticed? ______________________________

______________________________

Is your child teased about his/her speech problem by others? Yes ☐ No ☐

If "yes", please explain:______________________________

______________________________

What is your child's reaction to his/her speech problem? ________________________________

_______________________________________________________________________________

Has your child had a hearing examination prior to this time? Yes ☐ No ☐

If "yes", when? ______________________________________________________________

Where?_______________________________________________________________________

Has your child had a neurological examination prior to this time? Yes ☐ No ☐ If "yes", when? ______________________________________________________________

Where?_______________________________________________________________________

Has your child had a psychological examination prior to this time? Yes ☐ No ☐

If "yes", when? ______________________________________________________________

Where?_______________________________________________________________________

Has your child had an educational examination prior to this time? Yes ☐ No ☐

If "yes", when ______________________________________________________________

Where?_______________________________________________________________________

Has your child had a recent medical examination? Yes ☐ No ☐

If "yes", when? ______________________________________________________________

And by whom? ______________________________________________________________

If your child has had any of the above examinations, it will be helpful to the clinic if you contact the person who examined your child and ask them to send a copy of their findings to the address at the bottom of this page or fax it to 940-898-2276. If there is any additional information which you feel will help us to understand your child better, please describe:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

______________________________________ ______________________

Signature Date

Please complete the additional authorization forms that are attached. Once we have received this packet in our office, you will be contacted to schedule an evaluation.

If you have any questions, please contact the clinic at (940) 898-2285. You may mail this packet to the address below or e-mail to mzamoracalderon@twu.edu. You may also fax to (940) 898-2276.

Mail to:

Texas Woman's University
Speech, Language and Hearing Clinic – MCL 601
P.O. Box 425737
Denton, Texas 76204
Attn: Marisa