

SPEECH AND HEARING CLINIC
University of South Alabama
Department of Speech Pathology and Audiology
(251) 445-9378

Patient # _____

Date _____

CHILD CASE HISTORY FORM (AUDIOLOGY)

Child's Name _____ Birthdate _____ Age _____
Parents _____ Age (Mother) _____ (Father) _____
Address _____
Street City State Zip
Telephone _____ Emergency Telephone _____
Child's School _____ Grade _____
Parent's Occupation (Father) _____ (Mother) _____
Referred by _____

A. Auditory and Hearing Information

1. Do you feel that the child has a hearing problem? If so, why? _____

2. When was the hearing problem first noticed? _____
3. Does any member of the family have a hearing problem and/or wear a hearing aid? _____
4. Does the child have a history of ear infections? _____
5. Describe any previous treatment or testing the child has received regarding his/her ears or hearing.

6. Has the child ever been exposed to a loud noise or explosion? _____
7. Does the child ever complain about the fullness in his ear or noise in his ear? _____
8. Does the child become confused with which direction a sound is coming from? _____
9. Does the child seem to watch a speaker's face closely for cues as to what is being said? _____
10. Does the child respond to the following:
His/her name ____ Loud noises ____ Soft noises ____ Verbal commands ____ Vibrations ____
11. Check any of the following additional services which the child has received:
Speech/language evaluation Speech/language therapy
Psychological testing Special education
Neurological evaluation Physical therapy
Auditory processing evaluation Academic tutoring
Occupational therapy Genetic evaluation

B. Pregnancy and Birth Information

1. Any unusual illness during pregnancy? _____
(Measles, Rh factor, diabetes, toxemia, high blood pressure)
2. Length of pregnancy: _____ months/weeks
3. Length of labor: _____ hours
4. Child's birth weight: _____ lbs. _____ oz.
5. Check any of the following which apply:
Breech birth Planned C-section
Incubator used Emergency C-section
Instruments used Discoloration
Trouble breathing
6. History of miscarriage: _____ If yes, how many? _____

C. Developmental Information

1. List the age at which the child achieved the following skills:
a. Sat alone _____ b. Crawled _____ c. Walked alone _____
d. Fed self _____ e. Toilet trained _____ e. Dressed self _____
2. Child's physical development has been _____ (fast, slow, normal)
3. Which hand does the child prefer to use? _____

D. Medical Information

1. Check the illnesses or conditions the child has or has had in the past:

Coordination problems	Recurrent headaches	High fevers
Swallowing difficulties	Chicken pox	Tonsillitis
Serious accidents	Meningitis	Eye problems
Mumps	Feeding difficulties	Dizziness
Surgery	Convulsions	Measles
Frequent colds	Allergies	Flu
Mental retardation	Down syndrome	Cerebral palsy
Attention deficit disorder		

2. Describe any serious illnesses or accidents _____

3. List the names of any medications the child receives on a regular basis _____

E. Speech and Language Information

1. Did the child smile and cry appropriately as an infant? _____

2. At what age did the child do the following: Babble _____ Use words _____ Use phrases _____

3. Have you had any concern regarding the child's speech and language development? _____
If so, at what age did you first become concerned? _____

4. Do any family members have speech difficulties? _____ If yes, describe _____

5. Is the child aware of his/her communication problem? _____

6. Do you think the child is behind in other areas? _____ If yes, describe _____

7. How do you communicate with the child? _____

8. Can the child follow simple verbal instructions? _____

9. How does the child his/her needs known to you? _____

10. Check any of the following that apply to the child:

Poor listening comprehension	Pronounces sounds incorrectly	Talks very little
Leaves out words	Repeats or hesitates when talking	Cerebral palsy
Reverses word order	Uses incorrect or immature grammar	
Uses gestures rather than speech	Talks too rapidly or too slowly	

F. Behavioral information

Check any of the following that relate to the child's behavior:

Demands attention	Under unusual stress at home	Underactive
Easily frustrated	Lacks confidence	Behavioral problem
Short attention span	Talks excessively	Nervous or sensitive
Easily distracted	Easily managed at home	Tires easily
Hyperactive	Overly sensitive to loud noises	Lacks motivation
Cries easily	Confused in noisy places	Underachiever
Slow learner	Prefers to play alone	Daydreams
Impulsive	Withdrawn	Makes inappropriate statements

G. Educational Information

1. Has the child ever repeated a grade? _____ If so, what grade and why? _____

2. Has the child ever received any special help at school? _____ If so, describe _____

3. Does the child like school? _____

4. What are his/her best subjects? _____

5. Please indicate those subjects the child is having the most difficulty with _____

6. Has the child been a behavioral problem at school? _____ If so, describe _____

7. Have any of the child's teachers ever requested that his/her hearing or vision be tested? _____
8. Does the child have problems paying attention and following directions in the classroom? _____
9. Has the child ever been involved with alcohol and/or drugs? _____ If so, describe _____

10. Is there any history of learning problems in the family? _____
11. Please describe any further information about the child's behavior, schooling, health, etc., which you feel is important _____

ADDITIONAL COMMENTS:

Signature of person completing form