

SPEECH AND HEARING CLINIC

University of South Alabama
Department of Speech Pathology and Audiology
HAHN 1119
Mobile, AL 36888-0002
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Date _____

CHILD CASE HISTORY FORM (Speech-Language Pathology)

Child's Name _____ Birthdate _____

Male _____ Female _____

Address _____

Home Phone _____ Cell _____ city _____ state _____ zip code _____

Work _____

E-mail _____

Child's School _____ Grade _____

Child's Doctor _____

Persons Living in the Home:

Name	Age	Sex	Grade Reached	Employer
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Father				
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Mother				
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Others				
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A. Background Information

1. Who referred you to this Center? _____

2. Briefly describe the child's communication problem: _____

3. Describe previous treatment if any, for the problem: _____

4. Languages spoken in the home: _____

5. Check any of the following services which the child has received:

speech/language evaluation neurological evaluation special education

speech/language therapy genetic evaluation EMR class

Hearing evaluation occupational Therapy TMR class

Auditory processing evaluation physical therapy EEH class

Psychological testing academic tutoring LD class

Hearing impaired homebound

B. Pregnancy and Birth Information

1. Any unusual illness during pregnancy _____
(Measles, Rh blood factor, diabetes, high blood pressure)

2. Any history of maternal use of alcohol and/or drugs _____

3. History of miscarriage: yes no How many _____

4. Length of pregnancy: _____ months 5. Length of labor: _____ hours 6. Birth weight: _____

7. Child's condition at birth: _____ First APGAR: _____ Second APOAR: _____

8. Length of hospital stay after delivery: _____

Check any which apply:

breech birth C-section instruments used trouble breathing
 incubator used scars/bruises respirator used unusual color

C. Developmental Information: List age at which the child achieved the following skills:

Sat alone _____ Fed self _____ Physical condition has been:
Crawled _____ Toilet trained _____ __fast __slow __average
Walked unaided _____ Dressed self _____

D Medical Information: Check any illnesses/conditions child has had:

Coordination problems Ear infections/aches Tongue thrust
 Swallowing difficulty Frequent colds Cerebral palsy
 Feeding problems Convulsions/seizures Cleft palate
 Eye problems High fevers Mental retardation
 Allergies – List _____ Tonsillitis Autism
_____ Dental problems Brain injury

Describe any serious illnesses/accidents/surgery:

List medications child takes regularly: _____

E. Speech and Language Information

1. Did child smile and cry appropriately as an infant? _____
 2. At what age did child use single words? _____
 3. At what age were you first concerned about the child's communication? _____
 4. Do any family members have speech and/or hearing problems? Yes No
if so, describe _____
 5. Is there a history of mental retardation in your family? Yes No
 6. Is the child aware of his/her communication problem? Yes No
 7. Do you think the child is behind in other areas? Yes No
If yes, describe. _____
 8. Can the child be understood by others? Yes No Sometimes
 9. Does the child have a hearing problem? Yes No Has child's hearing been tested? _____
 10. Does the child wear a hearing aid? Yes No
 11. Check any of the following which apply to the child:
 Poor comprehension Uses incorrect/immature grammar Talks too rapidly
 Cannot follow directions Uses gestures rather than speech Talks too slowly
 Leaves out words in sent. Pronounces sounds incorrectly Voice sounds hoarse
 Reverses order of words Repeats or hesitates when talking Voice sounds nasal
 Talks very little Stutters or stammers Voice sounds "stopped up"
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F. Educational Information (if applicable)

1. Has the child ever repeated a grade? _____
If so, what grade and why? If so, describe. _____
2. Has the child ever received any special help at school? _____
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, vision or speech 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? _____

G. Behavioral Information: Check any of the following that relate to the child's behavior.

- | | | |
|--|---|---|
| <input type="checkbox"/> Nervous or sensitive | <input type="checkbox"/> Short attention | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Cries easily | <input type="checkbox"/> In "own world" |
| <input type="checkbox"/> Restless sleeper | <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Demands attention | <input type="checkbox"/> Slow learner | <input type="checkbox"/> Overly active |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Unusual fears | <input type="checkbox"/> Thumb sucker |
| <input type="checkbox"/> Prefers to play alone | <input type="checkbox"/> Overly talkative | <input type="checkbox"/> Wets bed |
| <input type="checkbox"/> Does not separate from parent | | |
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Additional comments:

Signature of person completing form