SPEECH AND HEARING CLINIC Patient #_____

University of South Alabama
Department of Speech Pathology and Audiology
(251) 445-9378

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
- ☐ Psychological testing
- ☐ Neurological evaluation
- ☐ Auditory processing evaluation
- ☐ Occupational therapy
- ☐ Speech/language therapy
- ☐ Special education
- ☐ Physical therapy
- ☐ Academic tutoring
- ☐ 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
- ☐ Incubator used
- ☐ Instruments used
- ☐ Trouble breathing
- ☐ Planned C-section
- ☐ Emergency C-section
- ☐ Discoloration

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 to 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