Indiana University
Robert L. Milisen Speech, Language & Hearing Clinics

Child Case History Form

Today's Date__________________

I. Identifying Information

Child's Name_____________________________________ Age______Birthdate____________
Sex of Child________
Child's Home Address______________________________
____
____
Names of Parents/Guardian____
Mother ______________________________
Father________________________
Address______________________________ Address______________________________
______________________________ ______________________________
______________________________ ______________________________
Occupation___________________________ Occupation___________________________
Phone: Home ( )_____________________ Phone: Home ( )_____________________
Work ( )_____________________ Work ( )_____________________

Are languages other than English (including sign language) used at home? _____yes _____no
If so, what language?____

II. Child Referred By:

Name____
Relationship to Child_________________________________
Address____
City______________________State__________Zip_______
Telephone ( )_____________________________________
Reason for referral:____
____
____
Person completing questionnaire:____

III. Statement of Concern

Describe your concerns about your child's speech/language and hearing:____________________

____

____

1. When was this concern first noticed?____________________By whom?___________________

2. What do you expect from this evaluation?____

   ____

3. Why are you seeking services at this center at this time?_______________________________

   ____

4. Hearing

Date of most recent hearing evaluation___________Results____________________________

Where was testing performed?____

By Whom?____

Yes	No	
___	___	Do you feel that the child hears well?
___	___	Has the child ever been exposed to a loud noise or explosion?
___	___	Has the child ever had an ear infection? If so, which ear_____________________
		Last occurrence___________First occurrence___________Frequency__________
___	___	Does the child presently have or in the past had draining ears (pus, blood, etc.)?
___	___	Does the child ever complain of ear noises (tinnitus) such as ringing, buzzing, pulsing, etc.?
___	___	Is the child able to locate the direction from which sound is coming?
___	___	Does your child hear the same from day to day?
___	___	Does your child favor one ear? If so, which ear____________________________
___	___	Does your child respond to vibration caused by loud sounds (door slam, truck driving by, airplane, radio in car, boom box vibration, etc.)?
___	___	Does the child watch the speaker's face when listening?
___	___	Does your child wear hearing aids?
		Right ear_____ Left ear_____ Both ears_____
		Make and Model____
		How long has he/she worn hearing aids?__________________________________
		How many hours a day does your child wear the hearing aids?________________

Speech/Language

1. Did the child begin to babble or talk and then stop? ___yes ___no
   If yes, please explain____
   ____
   ____

2. Please indicate all means of communication currently used:

___Speech	___Vocalizaions	___Bodily Gestures
___Facial Gestures	___Gestural (yes/no)	___Takes to item physically
___Spoken (yes/no)	___Manual Signs	___Pointing
___Augmentative Communication Device		

List any adaptive equipment currently used:____
____

3. At what age did your child say his/her first word?________________________________
   What were the child's first few words?____

4. Approximately how many words did the child have at
   18 months?___________ 24 months?____________

5. At what age did the child say his/her first sentence?______________________________
   Please give some examples of first sentences:_____________________________________
   ____
   ____
   Please give an example of typical sentences the child currently uses:___________________
   ____
   ____

6. How often does your child use speech? ___Frequently ___Sometimes ___Rarely

7. How does your child make his/her needs known?____________________________________

8. Does the child use gestures often? ___yes ___no if so, give an example__________________
   ____

9. What does the child use the most?
   ___Gestures ___Sounds ___One or two words ___Phrases ___Complete sentences

10. Estimate the percentage of time that the child is understood by:
    ___Unfamiliar listeners ___Parents ___Other adults ___Brothers and Sisters ___Friends

11. How well does the child understand what is said to him/her?____________________________

12. Please indicate the child's current level of understanding by checking those that apply:
    ___Understands gestures
    ___Does <u>not</u> understand spoken words
    ___Understands single words
    ___Understands simple sentences
    ___Understands 2 and 3 part commands
    ___Understands conversation

13. Do you think the child is aware of his/her communication difference? ___yes ___no
    If yes, please describe how the child shows awareness.________________________________
    ____
    ____
    ____

14. Provide any other information about your child's communication that is of concern to you.
    ____
    ____
    ____

15. What have immediate family and/or relatives done to help the child overcome his/her communication difficulty?
    ____
    ____

    Has this helped?____

16. What do you think caused this communication difference?____________________________
    ____
    ____
    ____

17. Please provide any additional information you feel will help us in understanding the child and his/her present communication ability.____
    ____
    ____

IV. Prenatal (pregnancy), Birth, and Development

1. **Prenatal**

Mother's age when child was born__________ Father's age when child was born_________

Length of pregnancy in weeks_________

Yes	No	
___	___	Did the mother experience bleeding during pregnancy?
___	___	Did the mother have measles during pregnancy?
___	___	Did the mother have high blood pressure during pregnancy?
___	___	Did the mother experience leakage of membranes during pregnancy?
___	___	Were there complications during this pregnancy? (anemia, dehydration, diabetes, kidney infection, sever nausea, toxemia, accidents, other) If so, please describe condition and medical attention received________________ ____
___	___	Were prescription/non-prescription drugs (including alcohol) taken during pregnancy? If so, please list____

2. **Birth**

Yes	No	
___	___	Did the mother have a normal delivery with this child?
___	___	Breech delivery?
___	___	Caesarean Section delivery?
___	___	Were there birth injuries? Please describe_________________________________
___	___	Breathing difficulties (e.g., blue baby, required oxygen, stopped breathing, apnea, other_____________)
___	___	Special instruments used during delivery?
___	___	Please describe____
___	___	Was the baby jaundiced at birth?
___	___	Rh incompatible?

Birth weight__________ One minute Apgar__________ Five minute Apgar_________

Were there any problems or complication immediately following birth or during the first two weeks of your infant's life (feeding, seizures, sleeping, swallowing, hospitalizations, etc.)?_____
____
____

How long was the infant's stay in the hospital following birth?___________________________

3. **Development** (give age when first occurred)

___________Held head up	___________Reached for object
___________Sat up unsupported	___________Crawled
___________Stood alone	___________Walked alone
___________Fed self with spoon	___________Bladder Trained
___________Bowel trained	___________Dressed Self
___________Undressed Self	

What motor &/or self-help development concerns do you have for this child?_________________
____
____

Would you describe your child's coordination as: _____good _____fair _____poor
Explain____
____

V. Child's Medical History

Name of child's Pediatrician/Doctor____
Address____Telephone__________________________
_
City__________________________________State___________________Zip__________________

Please check all conditions that your child has had or presently has:

General

___allergies	___asthma	___blood disease
___chicken pox	___convulsions	___crossed eyes
___croup	___dental problems	___diphtheria
___encephalitis	___epilepsy/seizures	___apraxia
___headaches	___head injury	___dysarthria
___heart problems	___high fevers	___influenza
___measles	___meningitis	___mumps
___muscle disorder	___nerve disorder	___traumatic brain injury
___pneumonia	___polio	___bronchopulmonary dysplasia
___rheumatic fever	___cerebral palsy	___tracheostomy
___whooping cough	___stroke	___RSV
___CHARGE association	___Failure to Thrive	___CMV (Cytomegalovirus)
___Feeding or swallowing problems	___HIV	___Gastroesophageal reflux
	___Fetal Alcohol Syndrome	___Neonatal Drug Dependence

Visual

1. Does your child wear glasses? ___yes ___no
2. Does your child have any visual problems? ___yes ___no If so, describe:______________

____

____

3. Date of most recent vision testing____
4. Where was the testing done?____
5. By whom was the testing performed?____

Ear, Nose, and Throat

Please check all conditions that your child has had or presently has:

___chronic cough/colds ___hoarse voice ___difficulty swallowing
___tonsillitis ___tonsillectomy ___adenoidectomy
___tongue deformity ___jaw deformity ___cleft palate/lip
___speech problem ___ear deformity ___dizziness
___too much wax in ears ___pressure equalization tubes

Please list any medications the child is taking presently:__________________________________

____

If your child has been seen by a medical specialist, hospital, clinic, agency, etc., please list below:

Agency/Specialist____ Date_________________

What was done____

Results/Recommendation____

Name____

Address____

Phone__________________________

Name____

Address____

Phone__________________________

Name____

Address____

Phone__________________________

VI. Educational History

Does your child attend ___day care ___kindergarten ___school ____other
Name of School______________________________Current Grade_____Type of Class_______
Address____Phone__________________
City_______________________County__________________State___________Zip_________
Teacher's Name____
Name of Speech Language Pathologist____
Name of Principal____

Previous Schools Attended:

Name of School	Address	Dates Attended
1.________________________	________________________	________________________
________________________	________________________	
2.________________________	________________________	________________________
________________________	________________________	
3.________________________	________________________	________________________
________________________	________________________	

Current grades for: Reading_____ Language_____ Spelling_____ Math_____

Does your child have a current IEP? ___Yes ___No

If yes, please have the school send a copy to this center.

VII. Cognitive History

Psychological Evaluation Completed:____
Date of most recent test:___________Where tested:______________________________________
By Whom?______________________________Test Results:___________________________
____

*Please provide the center with a copy of the Evaluation Report.

VIII. Home and Family

Please list other family member(s) who have a hearing loss (before age 50) or speech/language or learning difficulties (brothers, sisters, mother, father, and extended family such as grandparents, cousins, etc.):

Name	Date of Birth	Age	Sex	Communication/ Learning Concern	Relation to This Child
________________________	___________	___	___	________________	____________
________________________	___________	___	___	________________	____________

Please list everyone who lives with this child (i.e., brothers, sister, grandparents):

Name	Age	Sex	Relationship to this child
_____________________	___	___	____________________
_____________________	___	___	____________________
_____________________	___	___	____________________
_____________________	___	___	____________________

IX. List significant activities, interests, events, hobbies, favorite toys, etc. for this child.

____
____
____
____
____
____
____

The assessment can not proceed without the signature of the legal guardian.

Signature of Parent/Guardian________________________________

Date________________________________