Memphis Speech and Hearing Center
Child Case History

GENERAL INFORMATION:

Please describe your main concerns regarding your child's speech, language, or hearing problem:

Please list all additional children in the family:

Name	Sex	Age	Special Problems

PREGNANCY/BIRTH HISTORY:

Was the pregnancy normal? ☐ Yes ☐ No What was the length of pregnancy? _____

Was baby jaundiced (yellow)? ☐ Yes ☐ No What was the birth weight? _____

Newborn hearing screening? ☐ Pass ☐ Fail Length of baby's stay in hospital _____

Did the birth mother's history include any of the following: ☐ Alcohol ☐ Rh negative blood

☐ Smoking ☐ Herpes ☐ Toxemia ☐ Toxoplasmosis ☐ German measles ☐ Cytomegalovirus (CMV) ☐ Drugs

Please list drugs taken during pregnancy: _____

Please describe any complications with the pregnancy, birth, or birth defects _____

DEVELOPMENTAL HISTORY:

Child sat alone between the ages of 6 and 8 months. ☐ Yes ☐ No

Child walked alone between the ages of 12 and 15 months. ☐ Yes ☐ No

Are there any fine/gross motor difficulties we should be aware of to better serve your child? ☐ Yes ☐ No

Please explain: _____

Did your child grow at a normal rate? ☐ Yes ☐ No

SCHOOL:

Name of school or daycare _____ Grade: _____

Describe any problems your child is having in school (include special classes or programs):

What does the child's teacher say about his/her academic performance or classroom behavior?

Are you concerned with your child's performance in any subject? _____

BEHAVIOR AND SOCIAL HISTORY:

How does he/she interact with adults? ☐ Easily ☐ Average ☐ Reluctant

How does he/she interact with children? ☐ Easily ☐ Average ☐ Reluctant

Does the child separate easily from his/her parents or caregiver? ☐ Yes ☐ No _____

Does he/she have any behavior problems ☐ Yes ☐ No _____

MEDICAL HISTORY: Does the child have a history of any of the following?

Any type of medical diagnosis	☐ Yes	☐ No	Serious illness or injury	☐ Yes	☐ No
Convulsions, spasms or seizures	☐ Yes	☐ No	Serious high fevers	☐ Yes	☐ No
Clumsiness or weakness of arms and legs	☐ Yes	☐ No	Vomiting or headaches	☐ Yes	☐ No
Medical attention for a hearing problem	☐ Yes	☐ No	Ear, Nose, or throat defects	☐ Yes	☐ No
HIV/AIDs	☐ Yes	☐ No	Surgery	☐ Yes	☐ No

If yes, to any of the above items, please explain: _____

Check those that apply: ☐ Frequent colds ☐ Mumps ☐ Tonsillitis ☐ Chicken pox ☐ Asthma
☐ Encephalitis ☐ Meningitis ☐ P.E. tubes ☐ Measles

☐ Psychological testing or services ☐ Physical therapy ☐ Hearing services ☐ Speech/language therapy

☐ Occupational therapy ☐ Other services, please list: _____

Is there a history of hearing loss in the family? ☐ Yes ☐ No Relationship to child: _____

(OVER PLEASE)

Has the child had ear infections? ☐ Yes ☐ No Date of most recent: _____

Has your child had his/her vision tested? ☐ Yes ☐ No Results were: ☐ Normal ☐ Abnormal

Has your child had his/her hearing tested? ☐ Yes ☐ No Results were: ☐ Pass ☐ Fail

Please list all physicians and/or therapists your child sees regularly:

Physician/Therapist	Specialty	Reason

Additional medical information: _____

MEDICATIONS:

Please list all medications (prescribed or over the counter) that your child is currently taking on a regular basis. Include the medication's name, dosage, how often it's taken, and the route of administration.

_____

_____

ALLERGIES:

Please list any allergies (medication, Latex, food, environmental, etc.)

_____

_____

SPEECH AND HEARING:

Did the child speak his/her first word between the ages of 12 to 18 months? ☐ Yes ☐ No

Did the child combine two words together (i.e., "mommy go" or "want drink") by 24 months? ☐ Yes ☐ No

Did speech or language learning ever seem to stop? ☐ Yes ☐ No

Does your child have difficulty understanding directions or conversation? ☐ Yes ☐ No

Other than crying, would you say your child was: ☐ A silent baby ☐ A very quiet baby ☐ An average noisy baby ☐ A very noisy baby

Does your child respond to: ☐ His/her name ☐ Soft noises ☐ Vibrations ☐ Loud noises ☐ Verbal instruction ☐ Verbal instructions with gestures ☐ Gestures alone

How does your child make his/her needs known to you? _____

INTERPRETIVE SERVICES:

Client preferred language ☐ English ☐ Spanish ☐ Vietnamese ☐ Arabic ☐ Mandarin ☐ Other ☐ American Sign Language ☐ Communication Assistive Devices ☐ Unknown

Person with client preferred language ☐ English ☐ Spanish ☐ Vietnamese ☐ Arabic ☐ Mandarin ☐ Other ☐ American Sign Language ☐ Communication Assistive Devices ☐ Unknown ☐ No primary caregiver identified

SOCIAL HISTORY: *these questions must be addressed for patients 10 years old or older.

History of tobacco use ☐ Never smoked ☐ Former smoker (circle ceased smoking in last 30 days or >30 days)

☐ Current every day smoker ☐ Current some day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker

☐ Secondhand smoke exposure ☐ Type of tobacco ☐ Packs per day _____

Have you abused substances in the past 30 days? ☐ Yes ☐ No

If yes, type of substance: ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Methamphetamine ☐ Narcotics ☐ Sedatives ☐ Inhalants ☐ Hallucinogenic ☐ Ecstasy ☐ Ketamine ☐ Other _____

Substance amount _____ Date of last use: ___ / _____ / _____

Alcohol use/frequency ☐ None ☐ <12 drinks/week ☐ 12+ drinks/week ☐ 5+ drinks per occasion once/week

Alcohol amount _____ When was your last drink? _____

Person completing this form _____