CLEVELAND STATE UNIVERSITY ~ SPEECH & HEARING CLINIC

Audiology: Child Case History

Background Information

Name: _____ DOB: _____ Age: _____

Address: _____

Circle Preferred Contact: [H] _____ [W] _____

[Cell]_____ [Pager] _____

Mother's name: _____ Occupation: _____

Father's name: _____ Occupation: _____

Pediatrician: _____ Phone: _____

Person completing this form: _____ Referred by: _____

Statement of the Problem

Describe your child's speech, language and hearing problems: _____

_____

_____

When were the problems first noticed?_____

Previous test results: _____

Social and Environmental Factors

Is there a family history of hearing loss? _____ If yes, who? _____

Was your child born premature?_____ If so, how many weeks? _____ Birthweight:_____

Describe problems during pregnancy or delivery: _____

_____

_____

Birth defects: _____

Were there feeding problems? _____ If yes, describe: _____

Indicate siblings and other individuals living with the child:

Names	Ages	Relationship

Who is the caretaker when the parent is not available? _____

Medical History

What major illnesses has your child had? _____

Was your child ever hospitalized? _____ If so, describe _____

Check ☑ if your child has ever had the following and if so, describe.

- ☐ Seizures – describe _____
- ☐ High fevers – describe _____
- ☐ Allergies (food or environmental) – describe _____
- ☐ Middle ear infections – How many? _____ Last ear infection _____
  Method of treatment _____
- ☐ Ear surgery – describe _____
- ☐ Major injury – describe _____

List present medications and reason for the medication: _____

_____

_____

What other medical professionals have seen your child and for what reason? _____

_____

Communication History

Check ☑ if your child responds to:

☐ Adult voice	☐ Telephone	☐ Music
☐ A child's voice	☐ Doorbell	☐ TV

Does your child try to sing? _____ If yes, describe: _____

Does your child try to dance? _____ If yes, describe: _____

Has your child ever stopped babbling, talking or responding to sound? _____ If yes, how long? _____

_____

As a newborn, did your child startle to loud noises? _____

At 3-4 months, did your child turn his/her head toward sound? _____

Does his/her voice/cry sound normal to you? _____

At what age did your child:

Babble _____	Say first word _____
Use jargon _____	Use 2-word responses _____
Dance or move to music _____	

Check ☑ if your child uses:

☐ Gestures ☐ Phrases

☐ 1 or 2 word responses ☐ Sentences

Do parents or others easily understand your child? _____

How does your child show frustration? _____

_____

Developmental and Behavioral History

At what age did your child:

Sit alone_____ Feed self_____

Walk alone_____ Get toilet trained_____

Check ☑ if your child does any of these activities. If checked, describe below.

☐ pulls at ears ☐ has an unusual walk ☐ is inactive

☐ bangs his/her head ☐ has temper tantrums ☐ has problems sleeping

☐ loses his/her balance ☐ is hyperactive ☐ has problems attending to play

_____

_____

Does your child get along with other children?_____

Does he/she have friends? _____

How do you discipline your child?_____

_____

How many hours of TV does your child watch a day? _____ What are his/her favorite shows?

_____

What school does your child attend? _____

Check ☑ if your child has any of these problems at school. If checked, describe below.

☐ listening ☐ hearing/listening in noise ☐ writing

☐ paying attention ☐ reading ☐ math

☐ attending to an activity ☐ spelling ☐ following directions

_____

_____

What other types of services (i.e., Occupational Therapy, Physical Therapy, Speech Therapy, tutoring, psychologist, social services) does your child receive? Please give the names and addresses of providers.

_____

_____

_____

Additional Information

If there is any other information which would be helpful for us to know? _____

_____

_____

_____

_____

SAN/MW: 7/02