



MILLER SPEECH AND HEARING CLINIC
CHILD CASE HISTORY FORM

Child's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City/State/Zip Code: _____

Father's Name: _____ Father's Age: _____

Father's Address: _____ Occupation: _____

Father's Home Phone: _____ Work Phone: _____

Mother's Name: _____ Mother's Age: _____

Mother's Address: _____ Occupation: _____

Mother's Home Phone: _____ Work Phone: _____

Referred By: _____ Phone: _____

Family Physician: _____ Phone: _____

OTHER FAMILY MEMBERS LIVING WITH CHILD:

NAME AGE SEX GRADE SHCOOL SPECIAL EDUCATIONAL NEEDS
(If Yes, please describe)

Blank lines for entering family member information.

Are you Hispanic or Latino?

Yes No

Check one or more of the following groups in which you consider yourself to be a member of:

- American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White

What language(s) does the child speak? Does your child use sign language? _____

Which language system does your child prefer to use when communicating his or her needs/wants?

What language is spoken most often in the home? What other languages are spoken in the home?

Describe the child's speech, language, and/or hearing problem. _____

How does the child communicate (e.g., gestures, sign language, single words, phrases, sentences)?

At what age were you first concerned about the child's problem? _____

Has the child's problem changed in the last 6 months? If yes, describe _____

Does the child seem to be aware of his/her problem? If yes, what makes you think so? _____

What percent of what your child says can be understood by his/her parents? _____

Is there any history of speech-language-hearing problems in any family members? If yes, describe. ____

Does your child have any other problems or diagnoses that are influencing his/her development? _____

Has the child ever been seen for a speech or hearing evaluation or therapy? If yes, please give date(s), site(s), and results. _____

Has the child ever been seen by any other specialists? If yes, explain: _____

Check any of the following that describe the behavior of the child:

Nervous or sensitive _____

Has no playmates _____

Nightmares _____

Prefers to play alone _____

Temper tantrums _____

Easily managed _____

Overactive _____

Overly talkative _____

Cries Easily _____

Touches, clings to others _____

Likes school _____

Slow Learner _____

Behavior problem _____

Whiney _____

Friendly _____

Separates easily from parents _____

Enthusiastic _____

Cooperative _____

Easily distracted by movement _____

PRENATAL AND BIRTH HISTORY

Describe any unusual illness, condition, or accident during the pregnancy (German measles, Rh incompatibility, etc. _____

Is there any history of miscarriages? If yes, explain. _____

Was any medication taken during pregnancy? If yes, please describe. _____

Length of pregnancy: _____ Length of Labor: _____ Birth Weight: _____

Describe any problems during the delivery (breech birth, induced labor, etc.) _____

MEDICAL HISORY

Provide the approximate ages at which the child suffered any of the following illnesses or conditions:

- | | | |
|---------------------------|--------------------------|-----------------------------|
| Allergies _____ | Asthma _____ | Bronchitis _____ |
| Chicken Pox _____ | Colds _____ | Convulsions _____ |
| Croup _____ | Dizziness _____ | Ear Infections _____ |
| Encephalitis _____ | Flu _____ | Headaches _____ |
| High Fever _____ | Mastoiditis _____ | Measles _____ |
| Meningitis _____ | Mumps _____ | Pneumonia _____ |
| Seizures _____ | Sinusitis _____ | Sore Throat _____ |
| Tinnitus _____ | Tonsillitis _____ | Other _____ |

Does the child receive any medications at this time? Please explain. _____

Has the child had any surgeries? If yes, please provide age(s) and description(s). _____

DEVELOPMENTAL HISTORY

Provide the approximate age at which the child began to do the following:

Hold head up _____

Sit _____

Stand _____

Walk _____

Feed Self _____

Dress Self _____

Toilet Training Begun _____

Toilet Training Ended _____

Babble _____

Use of Words _____

Use Two-Word Phrases _____

Name Objects _____

Use Simple Questions _____

Engage In Conversation _____

Child's Present Weight _____

Child's Present Height _____

Child's physical development has been : **FAST** **NORMAL** **SLOW**

Child's coordination has been : **GOOD** **AVERAGE** **CLUMSY**

Have there ever been any feeding problems? If yes, describe. _____

Describe the child's response to sound (responds to all sounds, response to loud sounds only, etc.) _____

If your child has a hearing loss, please state the type of loss and age of onset. _____

If your child has a hearing loss, please describe any assistive devices (hearing aids, etc.) _____

EDUCATIONAL HISTORY

School: _____ - Grade: _____

At what age did the child start kindergarten or grade school? _____

Were any grades repeated? _____

What are the child's strongest subjects? _____

What subjects does the child have difficulty with? _____

How is the child doing academically? _____

Describe the child's overall progress in school? _____

How does the child interact with others? _____

Does your child receive any special services? If yes, describe. _____

If enrolled for special education services, has an Individualized Education Plan (IEP) been developed? If yes, describe the most important goals and when initial placement began. _____

If your child receives special education services but is also mainstreamed in regular education classes, please list classes for which the child is mainstreamed. _____

The Miller Speech and Hearing Clinic shall not discriminate on the basis of race, national origin, religion, age, sex, sexual orientation, or handicapping condition.

Person completing form _____

Relationship to Child _____

Signature _____ *Date* _____

I agree to permit Texas Christian University students, enrolled in pertinent academic training programs, to participate in the evaluation and/or treatment procedures which will be conducted under the supervision of the faculty of the clinical programs. In addition, I agree to permit the use of closed-circuit television, the taking of photographs or video recordings, audio recordings, or similar graphic material which are to be used for teaching or scientific purposes.

Signature _____ *Date* _____

I understand that the Miller Speech and Hearing Clinic does not file insurance for clinical services. Upon request, the clinic will supply me with an itemized statement that may be attached to my insurance form and submitted to my insurance company. I understand that all charges incurred are my responsibility and that insurance agreements are between the agency and the client, NOT the agency and Miller Speech and Hearing Clinic.

Signature _____ *Date* _____