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: ______________________

____

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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: ______________________

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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:________________________________

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

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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?________

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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

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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.

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Additional Information

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

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SAN/MW: 7/02