

THE SPEECH & HEARING CLINIC at  
TEXAS WOMAN'S UNIVERSITY  
Department of Communication Sciences & Disorders  
P O Box 425737  
Denton, TX 76204-5737  
Phone: 940-898-2285 Fax: 940-898-2070

**SPEECH-LANGUAGE-AUDIOLOGY  
CASE HISTORY  
FOR CHILDREN**

In preparation for your child's hearing and/or speech evaluation, we would like you to provide us with the following information. This information will assist the clinic staff in planning for and conducting a more meaningful examination. Please return this completed form to the above address as soon as possible so that an appointment time can be finalized for your child.

Please answer the questions as fully and accurately as possible. Many parents have found the child's baby book helpful in remembering particular dates. If you are not sure of a particular date, would you write the date that you think is correct and put a question mark after it. Your family physician may also be able to provide you with some information.

All of the following information is for the confidential use of the Speech-Language-Hearing Clinic staff only.

Date: \_\_\_\_\_

Person completing this form: \_\_\_\_\_  
Name Relationship to child

**I. REFERRAL**

Who referred your child to this clinic? \_\_\_\_\_

Professional title and/or relationship to the child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip

**Which of the following evaluations are you interested in?**  
 **Audiology**                       **Speech/Language**                       **Both**

What are your concerns in the areas of hearing, speech and language? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**II. IDENTIFICATION**

Child's name \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street

City State Zip  
Mother's name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Street

City State Zip

E-mail address: \_\_\_\_\_

Mother's occupation: \_\_\_\_\_ Work phone: \_\_\_\_\_

Father's name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: (if different than mother's) \_\_\_\_\_  
Street City State Zip

Father's occupation: \_\_\_\_\_ Work phone: \_\_\_\_\_

Highest grade completed by mother: \_\_\_\_\_ by father: \_\_\_\_\_

Are parents divorced? \_\_\_\_\_ If so, who has custody of the child? \_\_\_\_\_

If child isn't living with either biological or adoptive parent, who has legal guardianship?

\_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

If the parent(s) are employed outside the home, who cares for the child in their absence? \_\_\_\_\_

Family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

List Siblings	Age	Sex	Do they live in the home?
_____	_____	_____	_____
_____	_____	_____	_____

Does anyone in the family have speech or hearing problems? yes no If so, indicate relationship to child and explain the type of problem: \_\_\_\_\_

### III. BIRTH AND PRENATAL HISTORY

During this pregnancy, did mother experience any unusual illness, condition or accident, such as German Measles, false labor, RH incompatibility, etc? \_\_\_\_\_ If so, describe: \_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ Duration of labor: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Condition at birth:  Normal delivery  Caesarean  Breech birth

Anesthetics: yes no Forceps: yes no Was infant blue? yes no

Jaundiced: yes no Other unusual conditions? \_\_\_\_\_

Conditions immediately following birth:

Did infant have:  Feeding problems  Scars or bruises  Seizures  
 Swallowing or sucking difficulties Was birth weight regained quickly? yes no

Other (please explain) \_\_\_\_\_

### IV. DEVELOPMENT

When did your child:  
first hold up head up alone? \_\_\_\_\_

first crawl? \_\_\_\_\_

sit alone without support? \_\_\_\_\_

pull himself/herself to a standing position? \_\_\_\_\_

walk unaided? \_\_\_\_\_

gain bowel control? \_\_\_\_\_ bladder control? \_\_\_\_\_

Weight of your child at 6 months: \_\_\_\_\_ Weight at present: \_\_\_\_\_

Height at present: \_\_\_\_\_ Does your child prefer right or left hand? \_\_\_\_

Does your child fall or lost balance easily? \_\_\_\_\_

Does your child have  
     difficulty with balance?       fear of heights?       show fear if moved unexpectedly?

Are there activities that involve fast movements and spinning that your child finds difficult?

\_\_\_\_\_

Does your child like to go to Six Flags?  yes  no      Can your child ride a bike?  yes  no

Does your child seem awkward or uncoordinated?  yes  no

Does your child have difficulty chewing or swallowing?  yes  no

Describe any developmental difficulties: \_\_\_\_\_

Describe any academic difficulties: (reading, math, writing, spelling) \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

## V. MEDICAL

Check disease(s) your child has had, giving age and degree of severity:

<u>Disease</u>	<u>Age</u>	<u>Mild, average or severe</u>	<u>Disease</u>	<u>Age</u>	<u>Mild, average or severe</u>
allergies	_____	_____	kidney disease	_____	_____
asthma	_____	_____	measles	_____	_____
bronchitis	_____	_____	meningitis	_____	_____
chicken pox	_____	_____	mumps	_____	_____
colds (frequent)	_____	_____	ear infections	_____	_____
hay fever	_____	_____	pneumonia	_____	_____
headaches (frequent)	_____	_____	scarlet fever	_____	_____
heart disease	_____	_____	seizures	_____	_____

influenza \_\_\_\_\_ tonsillitis \_\_\_\_\_

Other illnesses not noted above: \_\_\_\_\_

Has your child ever had a fever of 103 degrees or more lasting more than 24 hours yes no  
or have there been changes in behavior following an illness? yes no

If so, please describe: \_\_\_\_\_

Has your child ever been hospitalized? yes no If so, when and for what reason? \_\_\_\_\_

If so, please state name of attending physician at time of hospitalization: \_\_\_\_\_

Is your child in good health at this time? yes no State any physical handicaps: \_\_\_\_\_

Does your child wear glasses? yes no Use a hearing aid? yes no

Health of other family members: \_\_\_\_\_

## VI. GENERAL DEVELOPMENT AND EDUCATION HISTORY

At what age did your child first start school? \_\_\_\_\_ Were any grades repeated? yes no

If so, which grades? \_\_\_\_\_ School attending now: \_\_\_\_\_

Address of school: \_\_\_\_\_ Phone: \_\_\_\_\_ Grade: \_\_\_\_\_  
City State

Teacher: \_\_\_\_\_ Principal: \_\_\_\_\_

Please name any subjects giving your child particular difficulty: \_\_\_\_\_

What are your child's usual grades?  
excellent above average average below average failing

What is your child's attitude toward:

school? \_\_\_\_\_

his/her homework? \_\_\_\_\_

How does your child get along with others at school? \_\_\_\_\_

Does your child sleep well? yes no      Does your child eat well? yes no

## VII. SOCIAL

What activities and games does your child enjoy? \_\_\_\_\_

Does your child tend to play alone or with other children? \_\_\_\_\_

What are the ages of his/her playmates? \_\_\_\_\_

Does your child show fear?            often            sometimes            rarely

What does he/she fear? \_\_\_\_\_

Is your child "nervous"? yes no      How does he/she show it? \_\_\_\_\_

Has he/she been harder to manage than other children? yes no

By whom and how is your child disciplined? \_\_\_\_\_

Is your child difficult to discipline? yes no      Explain: \_\_\_\_\_

---

Please check the boxes which identify your child's behaviors:

<input type="checkbox"/> lying	<input type="checkbox"/> sluggishness	<input type="checkbox"/> tongue sucking
<input type="checkbox"/> begging	<input type="checkbox"/> boastfulness	<input type="checkbox"/> strong fears
<input type="checkbox"/> stealing	<input type="checkbox"/> showing off	<input type="checkbox"/> strong hates
<input type="checkbox"/> smoking	<input type="checkbox"/> disobedience	<input type="checkbox"/> shyness
<input type="checkbox"/> rudeness	<input type="checkbox"/> destructiveness	<input type="checkbox"/> worrying
<input type="checkbox"/> swearing	<input type="checkbox"/> temper displays	<input type="checkbox"/> sensitivity
<input type="checkbox"/> fighting	<input type="checkbox"/> acts of violence	<input type="checkbox"/> easily depressed
<input type="checkbox"/> jealously	<input type="checkbox"/> quarrelsome behavior	<input type="checkbox"/> easily discouraged
<input type="checkbox"/> selfishness	<input type="checkbox"/> day-dreaming	<input type="checkbox"/> suicidal inclinations
<input type="checkbox"/> excitability	<input type="checkbox"/> thumb sucking	<input type="checkbox"/> running away from home
<input type="checkbox"/> skipping school	<input type="checkbox"/> nail biting	<input type="checkbox"/> associating w/bad company
<input type="checkbox"/> nose picking	<input type="checkbox"/> sex misbehavior	<input type="checkbox"/> prefers younger children
<input type="checkbox"/> sleeplessness	<input type="checkbox"/> convulsive behavior	<input type="checkbox"/> preference for older children
<input type="checkbox"/> nightmares	<input type="checkbox"/> sleepwalking	<input type="checkbox"/> snoring
<input type="checkbox"/> constipation	<input type="checkbox"/> fainting	<input type="checkbox"/> bed wetting
<input type="checkbox"/> mouth breathing	<input type="checkbox"/> face twitching	<input type="checkbox"/> complains of pain
		<input type="checkbox"/> night terrors

Are there any indications of your child not hearing plainly? yes no

Discuss any of the above items in more detail if you think they would shed light on the problem.

---

---

### VIII. SPEECH AND HEARING HISTORY

During your child's first 6 months, did he/she coo and babble? yes no

During the first year did he/she make many sounds other than crying? yes no

Other than crying, would you say your child was:

a silent baby?

an average baby?

a very noisy baby?

At what age did your child first say meaningful words? \_\_\_\_\_

What were they? \_\_\_\_\_

Did your child: say one or two words and then go for a long time before saying other words?  
or continuously add words once he/she started to talk?

At what age did your child begin to name people and objects? \_\_\_\_\_

At what age did your child have a name for everything? \_\_\_\_\_

At what age did your child combine words into small sentences like, "want drink" or "me out?"  
\_\_\_\_\_

At what age did your child combine short sentences?

Do you think your child has been slow in learning to talk? yes no

---

Does your child understand what you say as well as you think he/she should? yes no

If not, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child verbalize now? yes no If not, how does he/she make requests? \_\_\_\_\_  
\_\_\_\_\_

At this time does your child talk

a great deal?

an average amount?

very little?

Does your child's talking consist mainly of:

complete sentences?

phrases?

one or two words?

sounds?

How well can your child be understood by brothers, sisters, playmates?

1good            1sometimes            1not at all

Comments: \_\_\_\_\_

By adults other than family members?

1good            1sometimes            1not at all

Comments: \_\_\_\_\_

Did speech learning ever seem to stop for a period? 1yes    1no

If "yes", please describe:

\_\_\_\_\_  
\_\_\_\_\_

Has your child ever communicated better than they do now? 1yes    1no

If "yes", please explain:

\_\_\_\_\_

## **IX. OTHER INFORMATION**

If you suspect that your child has a hearing problem, when, why and by whom was the hearing problem first noticed? \_\_\_\_\_

Is your child teased about his/her speech problem by others? 1yes    1no

If "so", please explain: \_\_\_\_\_

What is your child's reaction to his/her speech problem? \_\_\_\_\_

Has your child had a hearing examination prior to this time? 1yes    1no    If so, when? \_\_\_\_\_

\_\_\_\_\_ Where? \_\_\_\_\_

Has your child had a neurological examination prior to this time? 1yes    1no    If so, when? \_\_\_\_\_

\_\_\_\_\_ Where? \_\_\_\_\_

Has your child had a psychological examination prior to this time? 1yes    1no    If so, when?

\_\_\_\_\_ Where? \_\_\_\_\_

Has your child had an educational examination prior to this time? yes no If so, when?

\_\_\_\_\_ Where? \_\_\_\_\_

Has your child had a recent medical examination? yes no If so, when? \_\_\_\_\_

and by whom? \_\_\_\_\_

If your child has had any of the above examinations, it will be helpful to the clinic if you will contact the person who examined your child and ask them to send a copy of their findings to the address at top of first page.

---

If there is any additional information which you feel will help us to understand your child better, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the space below, please give us the name, address and phone number of any facility/physician that you would like to have a copy of our findings sent to.

\_\_\_\_\_  
\_\_\_\_\_

I give my permission for the Texas Woman's University Speech & Hearing Clinic to release a copy of their findings to the above listed individuals/agencies.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

Thank you for your interest in our Speech-Language-Hearing Program at Texas Woman's University. If you have any questions, please call (940) 898-2285. Please return your completed case history to the following address.

Texas Woman's University  
Speech & Hearing Clinic  
P O Box 425737

**DEPARTMENT OF ACOMMUNICATION SCIENCES  
AND  
DISORDERS AT TEXAS WOMAN’S UNIVERSITY**

Speech – Language – Hearing Clinic

**Authorization for Evaluation/Treatment**

I hear by authorize the following for evaluation and/or treatment of

\_\_\_\_\_ client  
in speech & Hearing Clinic at Texas Woman’s University.

**Please Circle the choice(s) below**

Speech/Language

Audiological/Hearing

I hold the Speech & Hearing Clinic, Department of Communication Sciences and Texas Woman’s University harmless and waive and liability for injury, accident or illness to the client, caregivers, siblings, family members, or any other persons accompanying the client or family to the evaluation or therapy which may occur during or as the possible result of the course of evaluation/treatment.

It is my understanding that the examination findings and therapy reports will be treated as confidential materials and released only to such additional professional persons or agencies as I may authorize.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Parent/Guardian signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip