TEXAS WOMAN'S UNIVERSITY
Department of Communication Sciences & Disorders
P.O. Box 425737, Denton, TX 76204-5737
Phone: (940) 898-2285 | Fax: (940) 898-2276

SPEECH-LANGUAGE-AUDIOLOGY
CASE HISTORY
FOR CHILDREN

In preparation for your child's hearing and/or speech evaluation/therapy, 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 and/or therapy session. Please return this completed form as soon as possible so 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, 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: _____

Phone Number: _____

Which of the following evaluation(s)/and/or therapy are you interested in?

Audiology Evaluation ☐ Speech/Language Evaluation ☐ Both Evaluations ☐

Speech Therapy ☐

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

_____

_____

_____

II. IDENTIFICATION

Child's Name_____ Age: _____

Date of Birth: _____ Male ☐ Female ☐

Address: _____ Phone: _____
Street

_____
City State Zip Code

Mother's Name: _____ Age:_____

Address:_____ Home Phone:_____
Street

_____ Cell Phone: _____
City State Zip

Email Address: _____

Mother's Occupation: _____ Work Phone: _____

Father's Name: _____ Age:_____

Address:_____ Home Phone:_____
Street

_____ Cell Phone: _____
City State Zip

Email Address: _____

Father's Occupation: _____ Work Phone: _____

Highest grade level completed by mother:_____ By father: _____

Are parents divorced? Yes ☐ No ☐ If yes, 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:_____ Home Phone:_____
Street

_____ Cell Phone: _____
City State Zip

Family physician: _____ Phone: _____

List Siblings	Age	Male/Female	Do they live in the home?
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐

Does anyone in the family have speech or hearing problems? Yes ☐ No ☐

If yes, indicate the relationship to the child and explain the type of problem: _____

_____

_____

III. PRENATAL AND BIRTH HISTORY

During this pregnancy, did mother experience any unusual illness, condition or accident, such as German Measles, false labor, RH incompatibility, etc? Yes ☐ No ☐ If yes, please 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/swallowing or sucking difficulties ☐ Scars or bruises ☐
Seizures ☐ Was birth weight regained quickly: Yes ☐ No ☐

Other (please explain) _____

_____

IV. DEVELOPMENT

When did he or she first hold head up alone with no assistance? _____

Crawl? _____ Sit alone without support? _____

Pull himself/herself up to a standing position? _____ Walk unaided? _____

Gain bowel control? _____ Bladder control? _____

What is the child's present weight? _____

Present height? _____ Does your child prefer right or left hand? _____

Does your child fall or lose balance easily? Yes ☐ No ☐ If yes, please explain: _____

_____

Does your child have (check all that apply): 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? Please explain _____

_____

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) _____

_____

Additional comments: _____

_____

V. MEDICAL

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

Disease	Age	Mild, Average or Severe	Disease	Age	Mild, Average or Severe
Allergies	____	_____	Kidney disease	____	_____
Asthma	____	_____	Measles	____	_____
Bronchitis	____	_____	Meningitis	____	_____
Chicken Pox	____	_____	Mumps	____	_____
Colds(frequent)	____	_____	Ear Infections	____	_____
Hay Fever	____	_____	Pneumonia	____	_____
Headache(frequent)	____	_____	Scarlet Fever	____	_____
Heart Disease	____	_____	Seizures	____	_____
Influenza	____	_____	Tonsillitis	____	_____

Other illnesses not listed: _____

Any significant medical complications in the last year? Yes ☐ No ☐

If yes, please describe _____

_____

Have there been changes in behavior following any illnesses? Yes ☐ No ☐

If yes, please describe _____

_____

VI. GENERAL DEVELOPMENT AND EDUCATION HISTORY

At what age did your child first start school? _____ Were any grades repeated? Yes ☐ No ☐

If yes, which grades?_____ Name of school attending now _____

Current grade:_____ Teacher:_____

List any subjects giving your child particular difficulty: _____

_____

What are your child's usual grades? (check one)

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 ☐

If no, please describe _____

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 your child's playmates? _____

Is your child easily frustrated? 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:

☐excitability	☐day-dreaming	☐shyness
☐mouth breathing	☐easily discouraged	☐sensitivity
☐temper displays	☐prefers playing with younger children	☐prefers playing with older children
☐thumb sucking		

Are there any other behaviors you are concerned about? _____

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

_____

_____

VIII. HEARING HISTORY

Are there any indications of your child having difficulty with hearing? Yes ○ No ○

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

_____

Has your child had a hearing examination prior to this time? Yes ○ No ○

If yes, when? _____ Where and results? _____

XI. SPEECH AND LANGUAGE 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 such as cooing/babbling? 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 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"?

_____

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 no, please explain: _____

_____

Does your child use words to communicate now? Yes ☐ No ☐

If no, 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? ☐ single words? ☐ sounds?

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

☐ good ☐ sometimes ☐ not at all

Comments: _____

How well can your child be understood by adults other than family members?

☐ good ☐ sometimes ☐ not at all

Comments: _____

Did expressive speech ever seem to stop for a period? Yes ☐ No ☐

If "yes", please describe: _____

_____

Has your child ever communicated better than they do now? Yes ☐ No ☐

If "yes", please explain: _____

XII. OTHER INFORMATION

Has your child ever been hospitalized? Yes ☐ No ☐ If yes, when and for what reason?

_____

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 ☐

List the health of immediate family members and the relationship to the child: _____

_____

Is your child teased about his/her speech problem by others? Yes ☐ No ☐

If "yes", please explain: _____

_____

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

_____

Has your child had a neurological examination prior to this time? Yes ☐ No ☐

If "yes", when? _____

Where? _____

Has your child had a psychological examination prior to this time? Yes ☐ No ☐

If "yes", when? _____

Where? _____

Has your child had an educational examination prior to this time? Yes ☐ No ☐

If "yes", when _____

Where? _____

Has your child had a recent medical examination? Yes ❍ No ❍

If "yes", 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 the bottom of this page or fax it to 940-898-2276.

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

_____

_____

_____

_____

_____ _____

Signature Date

Please complete the additional authorization forms that are attached. Once we have received this packet in our office, you will be contacted to schedule an evaluation.

If you have any questions, please contact the clinic at 940-898-2285. You may mail this packet to the address below, or you may fax it to 940-898-2276.

Mail to:
Texas Woman's University
Speech & Hearing Clinic – MCL 601
P.O. Box 425737
Denton, Texas 76204

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Disclosure Form

_____	_____	_____
Patient Name (Please print)	Date of Birth	File#

Please read and initial in the space provided.

_____I understand that, by federal law, Texas Woman's University may not use or disclose my health information, except as provided in the University's Notice of Privacy Practices, without my authorization. My signature on this disclosure form indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release Texas Woman's University and its employees from any and all liability that may arise from the release of information as I have directed.

_____ I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to the person or institution named above. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

_____ I understand that copies of the Speech, Language, and Hearing Clinics HIPAA Privacy Practices are available to me in the clinic office.

_____ I understand that once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

This disclosure expires automatically upon _____
(Specify date, event, or one year from date of signature)

_____ I understand that I may refuse to sign this disclosure form. I also understand that the institution or individuals named above cannot deny treatment if I refuse to sign this disclosure form.

I have read and understand the information in this authorization form.

Signature of Patient or Legal Representative: _____

Please print name: _____ Date: _____

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AUTHORIZATION FOR CONFIDENTIALITY

I authorize that the evaluation and/or treatment procedures and information regarding the same may need to be e-mailed back and forth between Texas Woman's University and the parent/guardians and between the supervisors and students. I authorize that this procedure may be used to further the understanding between clinical personnel and parent/guardian. Should I choose not to authorize this communication, students and supervisors will communicate via an in-house secured network communication accessible only to personnel of the clinic, but will not use e-mail to communicate with me.

_____initial

I realize that the evaluation and/or treatment procedures might be observed in the room where the T.V. monitors are located or in the observation room by other parents/ guardians. Confidentiality will be maintained to the best extent possible. I understand that privacy will be observed as much as possible. Please respect the privacy of others while in the observation room.

_____initial

Due to patient and student education privacy laws, written permission is required for you to take photographs of our clinic sessions. Audio or video recordings of our clients or students are not permitted, except when made for student education purposes by clinic personnel.

_____initial

I understand that I may revoke my permission at any time by communicating in writing with the clinical coordinator.

_____ _____
Date Parent/Guardian Signature

_____
Client's Name

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AUTHORIZATION FOR RECORDING AND USE OF EVALUATION/TREATMENT PROCEDURES

I hereby authorize that the evaluation/treatment procedures of _____
Clients' Name
may be recorded, videotaped, photographed, and/or audio taped at the Department of Communication Sciences and Disorders at Texas Woman's University.

Yes ☐ No ☐ _____ Initial

I authorize that the recorded evaluation/treatment procedure may be used for educational and/or research purposes both within and outside the University.

Yes ☐ No ☐ _____ Initial

I authorize that the recorded evaluation/treatment procedure may be used for advertising purposes both within and outside the University.

Yes ☐ No ☐ _____ Initial

I authorize that the evaluation/treatment procedures may be observed and discussed by students in disciplines related to the Department of Communication Sciences and Disorders for academic purposes.

Yes ☐ No ☐ _____ Initial

Furthermore, I authorize that the evaluation/treatment data may be used for research purposes as approved by the appropriate University authorities.

Yes ☐ No ☐ _____ Initial

_____ _____
Date Client or Parent/Guardian Signature