

California State University, Fresno
Speech, Language and Hearing Clinic

5310 North Campus Drive M/S PH 80
Fresno, California 93740-8019
(559) 278-2422 ♦ Fax (559) 278-5187

CHILD CASE HISTORY

PLEASE PRINT IN INK OR TYPE ALL INFORMATION

General Information:

Today's Date: _____

Please Check One: Diagnostic Hearing Evaluation Individual Speech Therapy
 PUPS Preschool SEALS Preschool STARS Preschool

Child's Name: _____ **Date of Birth:** _____ **Gender:** _____

Address: _____ **City:** _____ **Zip:** _____

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

Mother's Occupation: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

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

Father's Occupation: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Does the child live with both parents? _____

If no, with whom does the child live? _____

Brothers and Sisters (include names and ages): _____

Emergency Contact Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Referred By: _____ **Phone:** _____

Physician: _____ **Phone:** _____

Address: _____

Office Use Only:

Date Received: _____

Dates Contacted: _____

Other specialists who have seen the child: _____

Please provide copies the most recent report for the Doctor, agency or school listed above.

Address: _____ **Phone:** _____

What were the other specialists' conclusions and/or recommendations? _____

What language (s) does the child speak? _____

How does the child usually communicate?

Gestures Sign Language Single Words Short Phrases Sentences

Describe the child's speech-language or hearing problem. _____

When was the problem first noticed? _____

Who first noticed the problem? _____

What do you think may have caused the problem? _____

Since you first noticed the problem, what changes have you observed in your child's speech, language, or hearing? _____

Is the child aware of the problem? _____

What have you done to help your child with the problem? _____

Describe other speech, language, or hearing problems in the family. _____

Prenatal and Birth History:

Describe mother's general health during pregnancy (illnesses, accidents, prescription and non-prescription medications, etc.). _____

Length of pregnancy: _____

Length of labor: _____

Child's general condition: _____

Birth weight: _____

Circle type of delivery: Head First Feet First Breech Cesarean

Were forceps used? _____

Child's length of stay in hospital: _____

Describe any unusual conditions that may have affected the pregnancy or birth. _____

Medical History:

Child's general health is: Good Fair Poor

Provide the approximate ages at which the child experienced the following illnesses and conditions.

Adenoidectomy _____	Asthma _____	Allergies _____
Chicken pox _____	Colds _____	Convulsions _____
Croup _____	Draining ear _____	Dizziness _____
Ear infections _____	Epilepsy _____	Encephalitis _____
German measles _____	Headaches _____	Hearing loss _____
Heart problems _____	High fever _____	Influenza _____
Measles _____	Mastoiditis _____	Meningitis _____
Mumps _____	Noise Exposure _____	Pneumonia _____
Seizures _____	Sinusitis _____	Tinnitus _____
Tonsillitis _____	Tonsillectomy _____	Visual Problems _____
Other _____	Glasses _____	

List child's current medications. _____

Describe any major accidents, surgeries, or hospitalizations the child has had. _____

Developmental History

Write the approximate age when the child began to do the following.

Crawl _____ Sit _____ Stand _____ Walk _____ Feed Self _____

Dress Self _____ Use toilet _____ Use single words _____ Combine words _____

Name simple objects _____ Use simple questions _____ Engage in a conversation _____

Does the child have any motor difficulty, such as walking, running, or participating in other activities which require small or large muscle coordination? _____

Describe any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.) your child has had. _____

Does the child:

Respond to any sounds? _____

Respond to the sound of the telephone bell? _____

Respond to the sound of human voices? _____

Respond to loud sounds only? _____

Respond to sounds inconsistently? _____

Seem to ignore sounds willfully? _____

Do you suspect any problems with hearing? _____

General Behavior

Does the child eat well? _____ Sleep well? _____

How does the child interact with other family members? _____

Is the child: Attentive Extremely Active Restless

Does the child bang his/her head, rock, or spin? _____

Does the child play by him/herself? _____

How does the child interact with other children? _____

Does the child lose his/her temper? _____

With whom does the child spend most of the day? _____

Educational History

School or Preschool: _____ Grade: _____

Teacher (s): _____

Describe any special services your child receives. _____

If enrolled for special education services, list main goals of the Individualized Educational Plan (IEP) or Individual Family Service Plan (IFSP). _____

Please add any additional information you feel might be helpful in the evaluation or treatment of the child's problem. _____

PLEASE ATTACH ANY REPORT YOU HAVE FROM ANOTHER AGENCY, SCHOOL OR DOCTOR.

Person completing the form: _____

Relationship to the child: _____

Signed: _____ Date: _____

*****Please Note:** You must complete and sign the attached Observation and Photo Consent statements and return them with your case history form. Thank you for taking the time to fill out the forms completely and accurately.

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Observation Consent

Consent is hereby given to faculty, students and other persons approved by the clinical supervisor at the Language, Speech and Hearing Clinic at California State University, Fresno to observe _____ in the clinic or in off campus settings.

Client Name

The purpose of these observations is to train University Communicative Sciences & Disorders students (both diagnostic and treatment sessions may be observed). Students from other departments studying children and adults with language, hearing, and speech disorders may also watch and listen if the supervisor gives permission.

Parent/Guardian/Self (18 or older)

Date

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Consent and Release for Photographs or Videotaping

Consent is hereby given to the Speech, Language, & Hearing Clinic, at California State University, Fresno, to take photographs, or videotape of _____. I understand that the photos/videos will be used to train University students and demonstrate department activities to the general public (e.g. CDDS department website or on Professional Health Services building bulletin boards).

I understand that I will be able to view the photographs or videotape if I request to do so.

Parent/Guardian/Self (18 or older) – Print Name

Date

Signature