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:_____ **Email:**_____

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

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

Father's Occupation: _____ **Email:**_____

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: _____

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Other specialists who have seen the child: _____

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

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

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