

**Indiana University
Speech, Language & Hearing Clinics**

**Pediatric Case History Form
Birth- 21**

Today's Date _____

Person filling out this form _____

I. Identifying Information

Child's Name _____ Age _____ Birthdate _____

Gender identity _____ Sex assigned at birth _____

II. Child Referred By:

Name _____

Relationship to Child _____

Address _____

City _____ State _____ Zip _____

Telephone () _____

Reason for referral: _____

III. Communication Profile

List significant activities, interests, events, hobbies, favorite toys, etc. for this child.

What language(s) are spoken in the home? _____

What language(s) do you use in your community? _____

Describe your concerns about your child's speech/language and hearing: _____

When was this concern first noticed? _____ By whom? _____

What do you expect from this evaluation? _____

Why are you seeking services at this clinic at this time? _____

Are there any religious or cultural beliefs/practices that should be considered in your child's care? Yes ___ No ___

Are you concerned about you or your family's level of anxiety and/or coping ability?

Yes ___ No ___

Is there anything that would limit your ability to attend regularly scheduled sessions?

No ___ Yes (If yes, please describe): _____

Is anyone at home, work, or school harming you or your child?

Yes ___ No ___

Hearing

Date of most recent hearing evaluation _____ Results _____

Where was testing performed? _____

By Whom? _____

Yes No

___ ___ Do you feel that the child hears well?

___ ___ Has the child ever been exposed to a loud noise or explosion?

___ ___ Has the child ever had an ear infection? If so, which ear _____

___ ___ Last occurrence _____ First occurrence _____ Frequency _____

___ ___ Does the child presently have or in the past had draining ears (pus, blood, etc.)?

___ ___ Does the child ever complain of ear noises (tinnitus) such as ringing, buzzing, pulsing, etc.?

___ ___ Is the child able to locate the direction from which sound is coming?

___ ___ Does the child hear the same from day to day?

___ ___ Does the child favor one ear? If so, which ear _____

___ ___ Does the child respond to vibration caused by loud sounds (door slam, truck driving by, airplane, radio in car, boom box vibration, etc.)?

___ ___ Does the child watch the speaker's face when listening?

___ ___ Does the child wear hearing aids?

___ ___ Right ear _____ Left ear _____ Both ears _____

___ ___ Make and Model _____

___ ___ How long have they worn hearing aids? _____

___ ___ How many hours a day does your child wear the hearing aids? _____

Speech/Language

1. Did the child begin to babble or talk and then stop? ___yes ___no

If yes, please explain _____

2. Please indicate all means of communication currently used:

___ Speech ___ Vocalizations ___ Bodily Gestures

___ Facial Gestures ___ Gestural (yes/no) ___ Takes to item physically

___ Spoken (yes/no) ___ Manual Signs ___ Pointing

___ Augmentative Communication Device ___ Photographs/pictures

___ Other communicative behaviors such as crying, smiling, screaming, physical behavior (e.g. hitting or dropping to the ground)

List any adaptive equipment or alternative augmentative communication modalities (e.g. PECS, signs, speech generating device, iPad app, etc.) that have previously or are currently used:

3. Did your child say their first word around one year of age and start speaking in +3-4 words sentences by age 3? Yes: If not, explain: _____

4. Please give an example of typical sentences the child currently uses: _____

5. How often does your child use speech? Frequently Sometimes Rarely

6. Does the child use gestures often? yes no if so, give an example _____

7. What does the child use the most?
 Gestures Sounds One or two words Phrases Complete sentences

8. What do they typically communicate about?
Requesting _____ Protesting _____ Commenting _____
Asking questions _____ Answering questions _____ Humor _____ Other: _____

9. Estimate the percentage of time that the child is understood by:
 Unfamiliar listeners Parents Other adults Brothers and Sisters Friends

10. How well does the child understand what is said to them? _____

11. Please indicate the child's current level of understanding by checking those that apply:
 Understands gestures
 Does not understand spoken words
 Understands single words
 Understands simple sentences
 Understands 2 and 3 part commands
 Understands conversation

12. Do you think the child is aware of their communication difference? yes no
If yes, please describe how the child shows awareness. _____

13. Provide any other information about your child's communication that is of concern to you.

14. What have immediate family and/or relatives done to help the child overcome the communication difficulty of your child? Has this helped?

15. What do you think caused this communication difference? _____

16. Please provide any additional information you feel will help us in understanding the child and his/her present communication ability. _____

IV. Adoption/ Foster Care

****Any information about the birth family history should be added in sections V and IX.**

1. Is your child in foster care? _____ Starting when? _____
2. Is your child adopted? ___yes ___no If yes, at what age was the child adopted? _____
3. Was it a domestic or international adoption? _____
4. If international, what country were they adopted from? _____
5. If international, were they in an orphanage or foster home before adoption? _____

V. Prenatal (pregnancy), Birth, and Development

1. Prenatal

Parent's age when child was born _____ Parent's age when child was born _____
Length of pregnancy in weeks _____

Yes No

____ Did the biological mother experience bleeding during pregnancy?
____ Did the biological mother have measles during pregnancy?
____ Did the biological mother have high blood pressure during pregnancy?
____ Did the biological mother experience leakage of membranes during pregnancy?
____ Were there complications during this pregnancy? (anemia, dehydration, diabetes,
kidney infection, severe nausea, toxemia, accidents, other)
If so, please describe condition and medical attention received _____

____ Were prescription/non-prescription drugs (including alcohol) taken during
pregnancy? If so, please list _____

2. Birth

Yes No

____ Did the biological mother have a normal delivery with this child?
____ Breech delivery?
____ Caesarean Section delivery?
____ Were there birth injuries? Please describe _____
____ Breathing difficulties (e.g., blue baby, required oxygen, stopped breathing, apnea,
other _____)
____ Special instruments used during delivery?
____ Please describe _____
____ Was the baby jaundiced at birth?
____ Rh incompatible?

Birth weight _____

Were there any problems or complication immediately following birth or during the first two weeks of your infant's life (feeding, seizures, sleeping, swallowing, hospitalizations, etc.)? _____

Were there any problems or complications following birth or delivery for the infant's birth parent? _____

How long was the infant's stay in the hospital following birth? _____

3. **Development** (please mark any of these milestones that did not happen, were delayed or concerning)

_____ Held head up	_____ Reached for object	_____ Crawled
_____ Sat up unsupported	_____ Stood alone	_____ Walked alone
_____ Fed self with spoon	_____ Bladder Trained	_____ Bowel trained
_____ Dressed Self	_____ Undressed Self	
_____ Other (please describe)		

Would you describe your child's coordination as: _____ good _____ fair _____ poor

VI. Child's Medical History

Please check all conditions that your child has had or presently has:

General

___ allergies	___ asthma	___ blood disease
___ chicken pox	___ convulsions	___ crossed eyes
___ croup	___ dental problems	___ diphtheria
___ encephalitis	___ epilepsy/seizures	___ apraxia
___ headaches	___ head injury	___ dysarthria
___ heart problems	___ high fevers	___ influenza
___ measles	___ meningitis	___ mumps
___ muscle disorder	___ nerve disorder	___ traumatic brain injury
___ pneumonia	___ polio	___ bronchopulmonary dysplasia
___ rheumatic fever	___ cerebral palsy	___ tracheostomy
___ whooping cough	___ stroke	___ RSV
___ CHARGE association	___ Failure to Thrive	___ CMV (Cytomegalovirus)
___ Feeding or swallowing problems	___ HIV	___ Gastroesophageal reflux
___ Other: _____	___ Fetal Alcohol Syndrome	___ Neonatal Drug Dependence
	___ Concussion	

ALLERGIES

MY CHILD IS ALLERGIC AND/OR HAS ADVERSE REACTIONS TO THE FOLLOWING: _____

Visual

- 1. Does your child wear glasses? yes no
- 2. Does your child have any visual problems? yes no If so, describe: _____

- 3. Date of most recent vision testing _____
- 4. Where was the testing done? _____
- 5. By whom was the testing performed? _____

Ear, Nose, and Throat

Please check all conditions that your child has had or presently has:

- | | | |
|---|--|--|
| <input type="checkbox"/> chronic cough/colds | <input type="checkbox"/> hoarse voice | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> tonsillitis | <input type="checkbox"/> tonsillectomy | <input type="checkbox"/> adenoidectomy |
| <input type="checkbox"/> tongue deformity | <input type="checkbox"/> jaw deformity | <input type="checkbox"/> cleft palate/lip |
| <input type="checkbox"/> speech problem | <input type="checkbox"/> ear deformity | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> too much wax in ears | <input type="checkbox"/> pressure equalization tubes | |

Please list any medications the child is presently taking:

If your child has been seen by a medical specialist, physical therapist, speech-language pathologist, occupational therapist, behaviorist, etc., please list below:

Agency/Specialist _____ Date _____
 What was done _____
 Results/Recommendation/Diagnosis _____

Agency/Specialist _____ Date _____
 What was done _____
 Results/Recommendation/Diagnosis _____

Agency/Specialist _____ Date _____
 What was done _____
 Results/Recommendation/Diagnosis _____

VII. Educational and Work History

Name of School _____ Current Grade _____
 Class Placement _____
 Address _____ Phone _____
 City _____ County _____ State _____ Zip _____
 Teacher's Name _____
 Name of Speech Language Pathologist _____
 Name of Principal _____

Previous Schools/Child Care Attended:

<u>Name of School/Child Care</u>	<u>Address</u>	<u>Dates Attended</u>
1. _____ _____	_____	_____
2. _____ _____	_____	_____
3. _____ _____	_____	_____

Does your child have challenges in any of these areas:

Reading _____ Language _____ Spelling _____ Math _____

Does your child have a current IEP? ___ Yes ___ No

If yes, please have the school send a copy to this center.

Adolescent Work Section

Employer/ Job Title: _____

Responsibilities: _____

Any challenges with these responsibilities: _____

VIII. Cognitive History

Psychological Evaluation Completed: _____

Date of most recent test: _____ Where tested: _____

By Whom? _____ Test Results: _____

*Please provide us with a copy of this Evaluation Report.

IX. Home and Family

Please list other family member(s) who have a hearing loss (before age 50) or speech/language or learning difficulties (siblings, parents, and extended family such as grandparents, cousins, etc.):

<u>Name</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Communication/ Learning Concern</u>	<u>Relation to This Child</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list everyone who lives with this child (i.e., siblings, grandparents):

<u>Name</u>	<u>Age</u>	<u>Relationship to this child</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The assessment cannot proceed without the signature of the legal guardian.

Signature of Parent/Guardian _____

Date _____