Hamilton
Hearing & Pediatric Rehabilitation

CASE HISTORY

Please fill in this History Form as completely and accurately as possible and return it to us prior to the evaluation. Use a separate sheet of paper, if necessary.

Date: _____

Name of person completing this form _____ Relationship to Child _____

I. IDENTIFYING INFORMATION:

1. Child's Name _____
   First Middle Last
2. Birthdate _____ Age _____ Race _____ Sex M F
3. How can we contact you? _____
4. Parents:
   Father_____ Age _____ Education _____
   Mother_____ Age _____ Education _____

5. Parents Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Separated ____
6. Number of Siblings _____ Birth order of this child _____
7. Languages spoken in the home _____
8. Primary language child hears at home _____
9. Child referred to this center by _____

II. BIRTH AND PRENATAL HISTORY: (Questions apply to birth of the child being seen)

1. Mother's health during pregnancy: Excellent_____ Good_____ Fair_____ Poor_____
2. Illness or accidents during pregnancy_____
3. Length of pregnancy (Months)_____
4. Place of birth (City/State) _____ Length of labor (hours)_____ Birth Weight_____
5. Were there any unusual problems at delivery? Yes_____ No_____
6. If Yes, explain_____
7. Type of delivery: Normal ____ Breech ____ Cesarean ____ Dry ____ High Forceps ____ Other ____
8. Age of mother at time of child's birth_____ Age of Father_____
9. Were any of the following procedures used during the first five days of the baby's life?
   Spinal tap ___ Skull X-ray___ Oxygen___ Chest X-ray___ Blood Transfusion___ Incubator___
10. Color at birth: Normal ____ Blue ____ Jaundice (Yellowish)_____
11. Any abnormalities or deformities not already mentioned? _____
12. Did the newborn baby ever have any of the following? (Check those that apply) Fever___
    Excessive Vomiting__ Allergies__ Bleeding__ Colic__ Feeding Problems__ Excessive Crying __
13. Length of stay in the hospital_____

III. DEVELOPMENT:

1. At what age did the child: Hold up head____ Sit alone____ Stand alone____ Walk alone____
   Feed himself____ Drink from a cup____ Dress without help____ Tie shoes____ Use scissors____
   Color within an outline____
2. When was he weaned? (Age)____ Did he use a pacifier? Yes ____ No____ Until What age? ____
   Did he suck his thumb or finger? Yes ___ No ___ Until what age? _____
3. At what age did he gain control of bladder while awake? _____ While asleep_____
4. At what age did he gain control of his bowels while awake?_____ While asleep_____
5. Which hand does he use?_____ At what age was this established_____
6. Does he have difficulty using his hands? Yes___ No___ If yes, explain_____
7. Does he have difficulty chewing? Yes_____ No_____ Swallowing? Yes_____ No_____

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IV. SOCIAL:

1. Does child spend all or part of his day with someone other than parents? Yes___ No___ If yes, please explain_____
2. Check all the following that apply: Enjoys being with people____ Entertains himself well____ Does not play well alone____ Has difficulty concentrating____ Is clumsy____ Is restless____ Is overactive____ Is underactive____ Is withdrawn and prefers to be alone____ Is unpopular and rejected____
3. How would you describe the child's temperament? Outgoing____ Shy____ Easy going____ Difficult____ Other_____
4. Which best describes your discipline: Firm____ Lenient (easy)____ Inconsistent____
5. What form of discipline is usually used? Verbal Reprimand____ Time Out____ Spanking____ Other (explain) _____
6. Has the child had any emotionally traumatic (shocking) experiences? Yes_____ No_____ If Yes, explain and describe the effect on the child_____

V. MEDICAL HISTORY:

1. Present state of child's health: Excellent_____ Good_____ Poor_____
2. Medical diagnosis, if any_____
3. Illnesses (Give ages the child had the following): German Measles_____ Red Measles_____ Croup_____ Scarlet Fever_____ Whooping Cough_____ Sinusitis_____ Rickets_____ Pneumonia_____ Diphtheria_____ Tonsillitis_____ Convulsions_____ Mumps_____ Ear aches/infections_____ Chronic Colds_____ Allergies_____ Meningitis_____ Encephalitis_____ Other illnesses and ages: _____
4. Are there any medical conditions that are significantly impacting on the development of the child_____
5. Describe any operations or accidents the child has had_____ Where was he/she hospitalized?_____ When?_____ How Long?_____
6. Is Child presently taking medication? Yes____ No____ Which ones?_____

VI. EDUCATION:

1. Did/does he attend Preschool? Yes___ No_____
2. Current School_____ Grade_____ Teacher _____
3. List any special classes he has attended or tutoring he has received (include Special Education, Occupational Therapy, Physical therapy etc.)_____
4. Has your child received Speech Therapy services?_____
5. Where and when did he receive Speech Therapy?_____ _____
6. What did Speech Therapy work on? (examples: pronunciation of sounds/words, understanding spoken language, increasing the words the child said etc.)_____ _____

VII. SPEECH AND LANGUAGE HISTORY:

1. Did he babble as an infant?_____ Age _____
2. At what age did he first say word(s)? _____ What were they?_____
3. At what age did he name objects/people? _____
4. At what age did he combine two or more words?_____
5. At what age did he begin to use sentences?_____

SPEECH AND LANGUAGE HISTORY CONTINUED:

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6. Did speech learning ever seem to stop for a period? Yes_____ No_____ If so, please explain _____
7. How does he make his needs known? Speech____ Gestures____ Both_____
8. Does he attempt to imitate speech? Yes_____ No_____
9. Does he excessively "parrot" or "echo" what is said to him? Yes_____ No_____
10. Does he speak primarily in whispered speech? Yes_____ No_____
11. Is his speech understandable to family? Yes_____ No_____ To others? Yes_____ No_____
12. Describe the child's speech problem_____
13. At what age was this speech problem noticed?_____ Has it improved? Yes_____ No_____
14. What have you done to help improve his speech?_____
15. Does he understand what is said to him? Yes_____ No_____
16. Is he ever teased about his speech? Yes_____ No_____
17. Does he hesitate and/or repeat sounds or words? Yes_____ No_____
18. Does he "get stuck" in attempting to say words? Yes_____ No_____
19. Does he have difficulty "finding" word(s) he wants to say? Yes_____ No_____
20. Does he have difficulty pronouncing certain sounds? Yes____ No____ If so, which ones?_____

VIII. AUDITORY BEHAVIOR:

1. Check all of the following that apply: Responds to most sounds____ Responds to loud sounds only____ Responds to sound consistently____ Deliberately ignores sounds____ Shows fear of sounds____ Responds to noises but not speech____
2. Has child ever had his hearing tested? Yes____ No____ By Whom?_____

IX. QUESTIONS:

What specific questions do you hope to have answered as a result of the speech evaluation?

1._____

2._____

3._____

4._____