UGA SPEECH AND HEARING CLINIC
The University of Georgia
Department of Communication Sciences and Special Education
706.542.4598 (office) 706.542.4574 (fax)

CHILD CASE HISTORY FORM (AUDIOLOGY)

Please complete this form. Attach copies of any additional information or reports that might assist us in our evaluation. Any information regarding your child will be handled in a confidential and secure manner.

Child's name: _____ Birthdate: _____ ☐ Male ☐ Female
First Middle Last

Address: _____
Street/PO Box City State Zip Code

Child's School: _____ Grade _____

Referred by: _____

Primary Physician: _____ Telephone: _____

Mother's/Guardian's Name: _____ Birthdate: _____

Address (if different): _____

Telephone: Home: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Father's/Guardian's Name: _____ Birthdate: _____

Address (if different): _____

Telephone: Home: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Telephone: _____
Name Relationship to Client

May we contact you regarding your appointment at any of the phone numbers or addresses listed above? ☐ Yes ☐ No
If no, please state where we **may not** contact you: _____

A. Auditory and Hearing Information

1. Do you feel your child has a hearing problem? If so, why? _____
2. When was the hearing problem first noticed? _____
3. Does your child have a history of ear infections? _____
4. Describe any previous treatment or testing your child has received regarding his/her ears or hearing: _____
   _____
5. Has your child ever been exposed to a loud noise or explosion? _____
6. Does your child ever complain about fullness or noise in the ears? _____
7. Does your child become confused with the direction from which sound is coming? _____
8. Does your child seem to watch a speaker's face closely for cues as to what is being said? _____
9. Does your child respond to the following?
   His/her name ____ Loud Noises____ Soft Noises ____ Verbal Commands___ Vibrations____
10. Check any of the following additional services which your child has received:
    ☐ Speech/language evaluation or therapy ☐ Academic tutoring ☐ Occupational therapy
    ☐ Psychological testing ☐ Special Education ☐ Genetic evaluation
    ☐ Neurological evaluation ☐ Physical therapy ☐ Auditory processing evaluation
11. Does any member of your family have a hearing problem and/or wear a hearing aid? ☐ Yes ☐ No If so, please describe:
    _____

B. Pregnancy and Birth Information

1. Any unusual illness during pregnancy? _____

   (Measles, Rh factor, diabetes, toxemia, high blood pressure)

2. Length of pregnancy: _____ months/weeks
3. Length of labor: _____ hours
4. Child's birth weight: _____ lbs. _____ oz.
5. Check any of the following which apply:

☐ Breech	☐ Planned C-section	☐ Trouble breathing/Required oxygen
☐ Incubator used	☐ Emergency C-section	☐ Jaundice
☐ Instruments used	☐ Discoloration	☐ Other_____

6. Was your child in Neonatal Intensive Care Unit? ☐ Yes ☐ No If yes, for what reason? _____ _____ For how long? _____

C. Developmental information

1. List the age at which your child achieved the following skills:

   a. Sat alone _____ b. Crawled _____ c. Walked alone _____

   d. Fed self _____ e. Toilet trained _____ f. Dressed self _____

2. Child's physical development has been _____ (fast, slow, normal)
3. Which hand does your child prefer to use? _____

D. Medical Information

1. Check the illnesses or conditions that your child has or has had in the past:

☐ Coordination problems	☐ Recurrent headaches	☐ High fevers	☐ Attention deficit disorder
☐ Swallowing difficulties	☐ Chicken pox	☐ Tonsillitis	☐ Cerebral Palsy
☐ Serious accident(s)	☐ Meningitis	☐ Eye problems	☐ Down Syndrome
☐ Mumps	☐ Feeding difficulties	☐ Dizziness	☐ Cognitive delays
☐ Surgery	☐ Convulsions/seizures	☐ Measles	☐ Flu
☐ Frequent colds	☐ Allergies		

☐ Other _____

2. List any current medications:

Medication	Dosage	Frequency	Route (Mouth/Injection/Patch, etc.)	Reason for Medication

E. Speech and Language Information

1. Have you had any concern regarding your child's speech and language development? ___
2. Did your child smile and cry appropriately as an infant? ☐ Yes ☐ No
3. At what age did your child do the following: Babble _____ Use words _____ Use phrases _____

4. Do any family members have speech difficulties? ☐ Yes ☐ No If yes, please describe. _____

_____

5. Is your child aware of his/her communication problem? _____
6. How do you communicate with your child? _____
7. Can your child follow simple verbal instructions? _____
8. How does your child make his/her needs known to you? _____
9. Check any of the following that apply to your child:

☐ Poor listening comprehension	☐ Pronounces sounds incorrectly	☐ Talks very little
☐ Leaves out words	☐ Repeats or hesitates when talking	☐ Difficulty maintaining eye contact
☐ Reverses word order	☐ Uses incorrect or immature grammar	
☐ Uses gestures rather than speech	☐ Talks too rapidly or too slowly	

F. Behavioral Information

Check any of the following that relate to your child's behavior:

☐ Demands attention	☐ Under unusual stress at home	☐ Impulsive
☐ Easily frustrated	☐ Lacks confidence	☐ Withdrawn
☐ Short attention span	☐ Talks excessively	☐ Nervous or sensitive
☐ Easily distracted	☐ Tires easily	☐ Makes inappropriate comments
☐ Hyperactive	☐ Overly sensitive to loud noises	☐ Lacks motivation
☐ Cries easily	☐ Confused in noisy places	☐ Underachiever
☐ Slow learner	☐ Prefers to play alone	☐ Daydreams

G. Educational Information

1. Has your child ever repeated a grade? _____ If so, which grade and why? _____

_____

2. Has your child ever received any special help at school? _____ If so, describe. _____

_____

3. Does your child like school? ☐ Yes ☐ No _____
4. What are his/her best subjects? _____
5. Please indicate the subjects that are difficult for your child: _____
6. Has your child been a behavioral problem at school? ☐ Yes ☐ No If so, describe. _____

_____

7. Have any of your child's teachers ever requested that his/her hearing or vision be tested? _____
8. Does your child have problems paying attention or following directions in the classroom? _____
9. Is there any history of learning problems in your family? _____
10. Please describe any additional information about your child's behavior, schooling, health, etc., which you feel is important.

_____

_____

_____

_____ _____

Signature of person completing the form **Relationship to client** **Date**