

# SPEECH AND HEARING CLINIC

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Date \_\_\_\_\_

## CHILD CASE HISTORY FORM (Speech-Language Pathology)

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip code \_\_\_\_\_

Work \_\_\_\_\_

E-mail \_\_\_\_\_

Child's School \_\_\_\_\_ Grade \_\_\_\_\_

Child's Doctor \_\_\_\_\_

### Persons Living in the Home:

Name	Age	Sex	Grade Reached	Employer
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Father \_\_\_\_\_

Mother \_\_\_\_\_

Others \_\_\_\_\_

### A. Background Information

1. Who referred you to this Center? \_\_\_\_\_

2. Briefly describe the child's communication problem:

\_\_\_\_\_

3. Describe previous treatment if any, for the problem:

\_\_\_\_\_

4. Languages spoken in the home:

\_\_\_\_\_

5. Check \_\_\_\_\_

Check any which apply:

breech birth       C-section       instruments used       trouble breathing  
 incubator used       scars/bruises       respirator used       unusual color

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**C. Developmental Information:** List age at which the child achieved the following skills:

Sat alone \_\_\_\_\_ Fed self \_\_\_\_\_ Physical condition has been:  
Crawled \_\_\_\_\_ Toilet trained \_\_\_\_\_ \_\_\_fast \_\_\_slow \_\_\_average  
Walked unaided \_\_\_\_\_ Dressed self \_\_\_\_\_

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**D Medical Information:** Check any illnesses/conditions child has had:

Coordination problems       Ear infections/aches       Tongue thrust  
 Swallowing difficulty       Frequent colds       Cerebral palsy  
 Feeding problems       Convulsions/seizures       Cleft palate  
 Eye problems       High fevers       Mental retardation  
 Allergies – List \_\_\_\_\_  Tonsillitis       Autism  
\_\_\_\_\_  Dental problems       Brain injury

Describe any serious illnesses/accidents/surgery:

\_\_\_\_\_

\_\_\_\_\_

List medications child takes regularly: \_\_\_\_\_

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**E. Speech and Language Information**

1. Did child smile and cry appropriately as an infant? \_\_\_\_\_
2. At what age did child use single words? \_\_\_\_\_
3. At what age were you first concerned about the child's communication? \_\_\_\_\_
4. Do any family members have speech and/or hearing problems? \_\_\_Yes\_\_\_No  
if so, describe \_\_\_\_\_
5. Is there a history of mental retardation in your family? \_\_\_Yes\_\_\_No
6. Is the child aware of his/her communication problem? \_\_\_Yes\_\_\_No
7. Do you think the child is behind in other areas? \_\_\_Yes\_\_\_No  
If yes, describe. \_\_\_\_\_
8. Can the child be understood by others? \_\_\_Yes\_\_\_No \_\_\_Sometimes
9. Does the child have a hearing problem? \_\_\_Yes\_\_\_No Has child's hearing been tested? \_\_\_\_\_
10. Does the child

10. Is there any history of learning problems in the family? \_\_\_\_\_

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**G. Behavioral Information:** Check any of the following that relate to the child's behavior.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Nervous or sensitive          | <input type="checkbox"/> Short attention  | <input type="checkbox"/> Withdrawn      |
| <input type="checkbox"/> Temper tantrums               | <input type="checkbox"/> Cries easily     | <input type="checkbox"/> In "own world" |
| <input type="checkbox"/> Restless sleeper              | <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Shy            |
| <input type="checkbox"/> Demands attention             | <input type="checkbox"/> Slow learner     | <input type="checkbox"/> Overly active  |
| <input type="checkbox"/> Aggressive                    | <input type="checkbox"/> Unusual fears    | <input type="checkbox"/> Thumb sucker   |
| <input type="checkbox"/> Prefers to play alone         | <input type="checkbox"/> Overly talkative | <input type="checkbox"/> Wets bed       |
| <input type="checkbox"/> Does not separate from parent |   |   |
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