UNIVERSITY OF SOUTH CAROLINA

Montgomery Speech, Language, and Hearing Clinic
803.777.2614 (MAIN LINE)
803.777-3081 (FAX)

CHILD CASE HISTORY FORM

PLEASE FILL OUT EACH SECTION COMPLETELY

PATIENT INFORMATION

DATE: _____

REFFERRED BY: _____

PATIENT NAME: _____ DATE OF BIRTH: _____ AGE: _____

RACE OF CHILD: _____ ETHNIC BACKGROUND OF CHILD: _____ GENDER:_____

PARENTS OR LEGAL GUARDIAN (NAMES): _____

ADDRESS: _____CITY/STATE: _____ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

COUNTY OF RESIDENCE: _____

FATHER'S OCCUPATION: _____ HIGHEST GRADE COMPLETED: _____

MOTHER'S OCCUPATION: _____ HIGHEST GRADE COMPLETED: _____

LIST OTHER LANGUAGES SPOKEN IN THE HOME: _____

HAS YOUR CHILD HAD A HEARING EVALUATION? YES ☐ NO ☐ NAME OF AUDIOLOGIST: _____

REPORTED RESULTS: _____ DATE OF EVALUATION:_____

HOW DOES YOUR CHILD COMMUNICATE? (BY SPEAKING, SIGNING, POINTING, ETC.) _____

DESCRIBE YOUR CHILD'S COMMUNICATION DIFFICULTY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____ INSURANCE ID NUMBER:_____
NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE CARRIER: _____ INSURANCE ID NUMBER: _____
NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

FAMILY SOCIAL HISTORY

LIST THE NAMES AND AGES OF OTHER CHILDREN IN THE HOME:

NAME	AGE

INDICATE ANY FAMILY HISTORY OF THE FOLLOWING SPEECH, LANGUAGE, HEARING, OR LEARNING DIFFICULTIES IN THE FAMILY.

	YES	NO	RELATIONSHIP
DIFFICULTY PRODUCING A FEW SOUNDS			
SPEECH DIFFICULT TO UNDERSTAND BY OTHERS			
STUTTERING			
HEARING LOSS			
LEARNING DISABILITY			
READING DIFFICULTY			
WRITING DIFFICULTY			
SPELLING DIFFICULTY			
DIFFICULTY UNDERSTANDING SPOKEN LANGUAGE			
GENETIC DISORDER			

NAME OF GENETIC DISORDER (IF APPLICABLE): _____

HEALTH HISTORY OF CHILD

PRE-NATAL HISTORY: CHECK ANY OF THE FOLLOWING THAT THE MOTHER EXPERIENCED DURING PREGNANCY WITH THIS CHILD

	YES	NO	DATE MM/YYYY		YES	NO	DATE MM/YYY
BLEEDING				GERMAN MEASLES/ RUBELLA			
SWELLING				DIABETES			
HIGH BLOOD PRESSURE				ACCIDENTS			
LOW BLOOD PRESSURE				X-RAYS			
CONVULSIONS				HEART CONDITION			
TOXEMIA				VIRAL INFECTION			
RH NEGATIVE BLOOD				THYROID CONDITION			

PLEASE LIST ANY OTHER CONDITIONS: _____

BIRTH HISTORY AND POST-NATAL PERIOD (TWO WEEKS OF INFANTS'S LIFE): CHECK ALL THAT APPLY.

	YES	NO	DATE MM/YYYY		YES	NO	DATE MM/YYYY
ANOXIA OR BREATHING DIFFICULTIES				EXTENDED HOSPITALIZATION OR RE-HOSPITALIZATION			
JAUNDICE				OXYGEN			
CONVULSIONS				TRANSFUSION			
INFECTION				TUBE FEEDING			
DEHYDRATION				PREMATURITY (37 WEEKS OR LESS)			
MALFORMATION OF HEAD, FACE OR NECK (E.G.: DYSMORPHIC APPEARANCE, CLEFT PALATE, ABNORMALITIES OF EAR, PERIAURICULAR TAGS/PITS)				OTOTOXIC DRUGS			

LENGTH OF PREGNANCY:_____ TYPE OF DELIVERY:_____

BIRTH WEIGHT:_____ TIME IN HOSPITAL FOLLOWING BIRTH:_____

MEDICAL HISTORY OF CHILD: CHECK ALL THAT APPLY

	YES	NO	DATE MM/YYYY		YES	NO	DATE MM/YYYY
FREQUENT COLDS				SCARLET FEVER			
EAR INFECTIONS				MUMPS			
PE TUBE INSERTION (FOR EARS)				WHOOPING COUGH			
PNEUMONIA				TONSILLECTOMY			
CHICKEN POX				ADENOIDECTOMY			
FLU				ALLERGIES			
MEASLES				EPILEPSY			
HEAD INJURY				ENCEPHALITIS			
SEIZURES				MENINGITIS			
LEAD EXPOSURE				VISION PROBLEMS			
FEEDING PROBLEMS				HEARING PROBLEMS			
SWALLOWING DIFFICULTY				SURGERIES			
DENTAL PROBLEMS				DIAGNOSIS OF HYPERACTIVITY			
DIAGNOSIS OF ATTENTION DEFICIT DISORDER				DIAGNOSIS OF AUTISM			
DIAGNOSIS OF PERVASIVE DEVELOPMENTAL DISABILITY				FAMILY HISTORY OF HEARING IMPAIRMENT IN CHILDHOOD			
HEAD TRAUMA				SYNDROMES			
HYDROCEPHALUS				TRISOMY 21 (DOWN SYNDROME)			
PULMONARY HYPERTENSION				ECMO			
CHARGE ASSOCIATION				OTHER CONDITIONS			

LIST ANY OTHER ILLNESSES HERE: _____

_____

PLEASE EXPLAIN ANY BOXES MARKED "YES":_____

_____

PLEASE LIST THE **NAME** AND **DOSAGE** OF ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING AND FOR **WHAT ILLNESS** THE MEDICINE IS PRESCRIBED:

NAME OF MEDICINE	DOSAGE	ILLNESS/CONDITION

HAS YOUR CHILD EVER BEEN SEEN BY A SPECIALIST OR PHYSICIAN OTHER THAN HIS/HER PEDIATRICIAN? YES ☐ NO ☐

IF YES, WHO? _____ WHEN? _____

OUTCOME: _____

HAS YOUR CHILD HAD ANY UNUSUAL ILLNESSES OR HOSPITALIZATIONS? YES ☐ NO ☐

IF YES, PLEASE DESCRIBE: _____

HAS YOUR CHILD'S SPEECH AND LANGUAGE BEEN EVALUATED? YES ☐ NO ☐

IF YES, WHEN? _____BY WHOM? _____

WHAT WERE THE RESULTS? _____

DESCRIBE YOUR CHILD'S SPEECH AND LANGUAGE DEVELOPMENT: _____

_____

DOES YOUR CHILD HAVE DIFICULTY FOLLOWING DIRECTIONS? YES ☐ NO ☐

DO YOU THINK YOUR CHILD HEARS ADEQUATELY? YES ☐ NO ☐

IS YOUR CHILD SENSITIVE TO ENVIRONMENTAL SOUNDS? YES ☐ NO ☐

IF YES, PLEASE DESCRIBE: _____

DEVELOPMENTAL HISTORY

HAS YOUR CHILD'S MOTOR DEVELOPMENT PROGRESSED AGE APPROPRIATELY? YES ☐ NO ☐

WHAT AGE DID YOUR CHILD:

	AGE (MONTHS/YEARS)		AGE (MONTHS/YEARS)
SIT ALONE		SAY FIRST WORD	
CRAWL		COMBINE 2 WORDS	
WALK ALONE		FEED SELF	
BABBLE		TOILET INDEPENDENTLY	
COMBINE 3 OR MORE WORDS			

LIST SEVERAL OF YOUR CHILD'S FIRST WORDS: _____ _____ _____

LIST SEVERAL OF YOUR CHILD'S PHRASES: _____ _____ _____

DESCRIBE YOUR CHILD'S PLAY BEHAVIOR:_____

DESCRIBE YOUR CHILD'S INTERESTS: _____

DESCRIBE YOUR CHILD'S BEHAVIOR WITH PLAYMATES, FAMILY MEMBERS, ETC.:_____

_____

EDUCATIONAL/HABILITIVE HISTORY

NAME OF SCHOOL: _____

TYPE OF CLASSROOM: REGULAR EDUCATION ☐ SPECIAL ED ☐ HEARING IMPAIRED ☐

TEACHER'S NAME (GRADE OR HOMEROOM): _____

FAVORITE SUBJECT: _____

ANY ATTENDING DIFFICULTIES? (PLEASE DESCRIBE) _____

ANY ACADEMIC DIFFICULTIES? (PLEASE DISCRIBE) _____

HAS YOUR CHILD RECEIVED SPEECH THERAPY IN THE PAST? YES ☐ NO ☐

IF YES, WHERE AND FOR HOW LONG? _____

DOES YOUR CHILD CURRENTLY RECEIVE:

SPEECH THERAPY? YES☐ NO☐ PHYSICAL THERAPY? YES☐ NO☐ OCCUPATIONAL THERAPY? YES ☐ NO☐

IF YES:

WHERE IS YOUR CHILD RECEIVING THERAPY? _____

WHAT IS YOUR CHILD'S DIAGNOSIS? _____

HOW LONG HAS YOU CHILD BEEN RECEIVING THERAPY? _____

PLEASE ADD ANY INFORMATION OR COMMENTS THAT YOU THINK MIGHT BE HELPFUL TO US. _____

_____

_____

_____