INDIANA UNIVERSITY

Hearing Clinic
Indiana University Health Sciences Building
2631 E. Discovery Parkway
Bloomington, IN 47408

Child Case History

Date: _____ Person Completing questionnaire: _____

Child's Name: _____ Age: _____ Birth date: ____-____-____

Sex assigned at birth: □ M □ F Gender Identity: _____

Address: _____Apt#: _____ City:_____

State: _____ Zip: _____

Parent/Guardian:

Name:_____

Address:_____

_____

Occupation: _____

Work: (___)_____

Home: (___)_____

Cell: (___)_____

Email address: _____

Parent/ Guardian:

Name: _____

Address: _____

_____

Occupation: _____

Work: (___)_____

Home: (___)_____

Cell: (___)_____

Email address: _____

Are languages other than English (including Sign Language) used at home? □ Yes □ No

What languages? _____

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

Please explain: _____

Are you concerned about you or your family's level of anxiety and/or coping abilities? □ Yes □ No

Referral Source Information

Name: _____ Relationship to child: _____

Reason for referral: _____

_____

_____

Statement of Concern

Describe your concerns regarding the child's speech/language and/or hearing: _____

_____

_____

When was this concern first noticed? _____By Whom? _____

What do you expect from this evaluation? _____

_____

_____

Hearing History and Concerns

Did the child pass the newborn hearing screening? □ Yes □ No

Has the child ever had a hearing evaluation? □ Yes □ No When?_____

Where was the evaluation performed? _____

By whom?_____

Results: _____

Yes	No	
□	□	Do you feel the child hears well?
□	□	Has the child ever been exposed to a loud noise or explosion?
□	□	Has the child ever had an ear infection? Which ear? □ Left □ Right □ Both First Occurrence: _____ Last Occurrence: _____ Frequency: _____
□	□	Does the child currently have or ever had draining ears (pus, blood, etc.)?
□	□	Does the child ever complain of ear noises such as ringing, buzzing, pulsing, etc? In which ear is the sound heard? _____
□	□	Does the child hear the same from day to day?
□	□	Does the child favor one ear? Which ear? □ Left □ Right
□	□	Does the child respond to vibrations caused by loud sounds (door slam, truck driving by, airplane, radio in the car, stereo vibration, etc.)?
□	□	Does the child wear amplification? □ Left □ Right □ Binaural Make and Model: _____ How long has he/she/they worn amplification? _____ How many hours a day does the child wear the amplification? _____

Speech-Language History Concerns

Did the child begin to babble or talk and then stop? □ Yes □ No

Please explain: _____

_____

Please check all the means of communication the child currently uses:

□ Speech □ Vocalizations □ Bodily Gestures □ Pointing □ Hand signs □ Spoken Yes/No

□ Facial Gestures □Gestural Yes/No □ Take to item physically

Please list adaptive equipment currently used: _____

_____

At what age did he/she/they say his/her/their first word? _____

Please give examples of his/her/their first words: _____

Approximately how many words did the child use at 18 months: _____ 24months _____

At what age did the child say his/her/their first sentence? _____

Please give examples of his/her/their first sentences: _____

_____

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

_____

How often does the child use speech? □ Frequently □ Sometimes □ Rarely

How does the child make his/her/their needs known? _____

Does the child use gestures? □ Yes □ No Please give examples: _____

_____

What does the child use most? □ Gestures □ Sounds □ One or two words □ Phrases

□ Complete Sentences □ Sign Language

Does the child use sign language? □ Yes □ No Type of sign language: _____

□ Baby Sign/hand babble □ Single words □ Phrases □ Complete thoughts/storytelling

Estimate the percentage of time that the child is understood by:

_____ Unfamiliar listeners _____ Parents _____ Other adults _____Siblings _____Friends

How well does the child understand what is communicated to him/her/them?

_____

Please indicate the child's current level of understanding: (check all that apply)

□ Understands gestures □ Does **NOT** understand spoken words □ Understands single words

□ Understands simple sentences □ Understands 2- and 3-part commands □ Understands conversation

Do you think the child is aware of his/her/their communication difference? □ Yes □ No □ Unsure

If so, please describe how the child shows awareness: _____

_____

_____

Provide any other information about the child's communication that is of concern to you: _____

_____

_____

What have immediate family and/or relatives done to help the child overcome his/her/their communication differences? _____

_____

_____

Has this helped? _____

What do you think caused this communication difference? _____

_____

_____

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

_____

Adoption/Foster Information

Is the child in adoptive or foster care? □ Yes □ No

Date of adoption/ foster care placement: _____

Birth country of child: _____ Child's placement prior to adoption: _____

Prenatal (pregnancy), Birth, and Development

Biologic mother's age when child was born:_____ Biologic father's age when child was born:_____

Length of pregnancy in weeks: _____

Prenatal:

Yes	**No**	
□	□	Did the biologic mother experience bleeding during pregnancy?
□	□	Did the biologic mother have measles during pregnancy?
□	□	Did the biologic mother have high blood pressure during pregnancy?
□	□	Did the biologic mother experience leaking of the membranes during pregnancy?
□	□	Were there complications during this pregnancy (anemia, dehydration, diabetes, kidney infection, severe nausea, toxemia, accidents, etc.)? Please describe the complication(s) and treatment(s):_____

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

Birth

Yes **No**

□ □ Vaginal delivery?

□ □ Breech delivery?

□ □ Caesarean Section delivery?

□ □ Were there birth injuries? Please describe: _____

□ □ Breathing difficulties? (e.g., blue baby, required oxygen, stopped breathing, etc.)
Please describe: _____

□ □ Special instruments used during delivery? Please describe: _____

□ □ Was the baby jaundice at birth? Treatment needed? _____

□ □ Rh incompatible?

Birth weight: _____lbs. _____oz. 1 minute Apgar_____ 5 minute Apgar _____

How long was the infant's stay in the hospital following birth? _____ □day(s) □week(s) □month(s)

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

_____

_____

Development

Give age when first occurred:

_____ Held head up	_____ Reached for an object	_____ Sat up unsupported
_____ Crawled	_____ Stood alone	_____ Walked alone
_____ Fed self with spoon	_____ Bladder trained	_____ Bowel trained
_____ Undressed self	_____ Dressed self	

What motor and/or self-help development concerns do you have for the child? _____

_____

Would you describe the child's coordination as □ Good □ Fair □ Poor

Please explain: _____

_____

_____

Child's Medical History

Pediatrician/Doctor: _____

Address:_____ City:_____ State:_____ Zip:_____

Phone: (___)_____

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

☐ allergies	☐ blood disease	☐ convulsions	☐ asthma	☐ chicken pox
☐ crossed eyes	☐ dental problems	☐ influenza	☐ diphtheria	☐ measles
☐ bronchopulmonary	☐ whooping cough	☐ encephalitis	☐ meningitis	☐ stroke
☐ croup	☐ epilepsy/ seizures	☐ cerebral palsy	☐ mumps	☐ apraxia
☐ muscle disorder	☐ nerve disorder	☐ tracheostomy	☐ headaches	☐ head injury
☐ dysarthria	☐ heart problems	☐ pneumonia	☐ RSV	☐ dysplasia
☐ polio	☐ rheumatic fever	☐ failure to thrive	☐ high fevers	☐ CHARGE
☐ CMV	☐ HIV	☐ feeding or swallowing problems		
☐ gastro esophageal reflux		☐ traumatic brain injury		

Visual

Does the child wear glasses? ☐ Yes ☐ No

Does the child have any visual problems? ☐ Yes ☐ No Please describe:_____

_____

Date of most recent vision testing: _____

Where was this testing completed and by whom? _____

Ear, Nose and Throat

Please check all the conditions that the child currently has or has had:

☐ chronic coughs/colds	☐ hoarse voice	☐ difficulty swallowing	☐ tonsilitis
☐ tonsillectomy	☐ adenoidectomy	☐ PE tubes	☐ dizziness
☐ jaw deformity	☐ cleft lip/palate	☐ tongue deformity	☐ ear deformity
☐ excessive wax in ears	☐ speech problems		

Please list any medications the child is currently taking: _____

_____

If the child has been seen by a medical specialist, hospital, clinic, agency, etc., please list below:

Agency/Specialist **Date** **What was done?** **Results/Recommendations**

Name: _____
Address: _____
_____
Phone: _____

Name: _____
Address: _____
_____
Phone: _____

Educational History

Does your child attend: □ daycare □ kindergarten □ school □ other_____

Name of current school: _____Current Grade: _____

Address: _____ Phone: _____

City:_____ County:_____ State: _____ Zip:_____

Teacher's Name: _____

Speech-Language Pathologist's Name: _____

Principal's Name: _____

Previous Schools Attended

Name of School: **Address:** **Dates Attended:**

1.

2.

3.

Current grades for: Reading _____ Language _____ Spelling _____ Math _____

Does the child have a current IEP? □ Yes □ No

If yes, please have the school send a copy to the Speech, Language and Hearing Clinic, Attn: Audiology

Cognitive History

Psychological evaluation completed? □ Yes □ No

If yes, please provide the Speech, Language and Hearing Clinic with a copy of the evaluation report.

Date of most recent test: _____ Where tested? _____

By whom? _____ Test Results: _____

_____

Home and Family

Please list any biologic family members who have a hearing loss (before the age of 50) including brothers, sisters, mother, father, and extended family such as grandparents and cousins, etc.

Name:	DOB:	Age:	Hearing Concern:	Relation to this child:
•				
•				
•				
•				

Please list any biologic family members with speech/language or learning difficulties (including brothers, sisters, mother, father, and extended family such as grandparents and cousins, etc.)

Name:	DOB:	Age:	Communication/ Learning Concern:	Relation to this child:
•				
•				
•				
•				
•				

Please list everyone who lives with this child:

Name:	Age:	Relationship to this child:
•		
•		
•		
•		
•		

List of significant activities, interests, events, hobbies, favorite toys, etc.

-
-
-
-
-

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

Signature of parent/guardian: _____Date: _____

Please bring the completed forms with you to the child's appointment. Thank you!