Indiana University
Speech, Language & Hearing Clinics

Pediatric Case History Form
Birth- 21

Today's Date_____
Person filling out this form_____

I. Identifying Information
Child's Name_____ Age_____Birthdate_____
Gender identity _____ Sex assigned at birth _____

II. Child Referred By:
Name_____
Relationship to Child_____
Address_____
City_____State_____Zip_____
Telephone ( )_____
Reason for referral:_____
_____
_____

III. Communication Profile
List significant activities, interests, events, hobbies, favorite toys, etc. for this child.
_____

What language(s) are spoken in the home? _____

What language(s) do you use in your community? _____

Describe your concerns about your child's speech/language and hearing: _____
_____
_____

When was this concern first noticed? _____By whom?_____

What do you expect from this evaluation? _____
_____

Why are you seeking services at this clinic at this time?_____
_____

Are there any religious or cultural beliefs/practices that should be considered in your child's care? Yes ___No____
Are you concerned about you or your family's level of anxiety and/or coping ability?
Yes___ No____
Is there anything that would limit your ability to attend regularly scheduled sessions?
No_____ Yes (If yes, please describe):_____

Is anyone at home, work, or school harming you or your child?
Yes___ No____

Hearing

Date of most recent hearing evaluation_____Results_____
Where was testing performed?_____
By Whom?_____

Yes	No	
___	___	Do you feel that the child hears well?
___	___	Has the child ever been exposed to a loud noise or explosion?
___	___	Has the child ever had an ear infection? If so, which ear_____
		Last occurrence_____First occurrence_____Frequency_____
___	___	Does the child presently have or in the past had draining ears (pus, blood, etc.)?
___	___	Does the child ever complain of ear noises (tinnitus) such as ringing, buzzing, pulsing, etc.?
___	___	Is the child able to locate the direction from which sound is coming?
___	___	Does the child hear the same from day to day?
___	___	Does the child favor one ear? If so, which ear_____
___	___	Does the child respond to vibration caused by loud sounds (door slam, truck driving by, airplane, radio in car, boom box vibration, etc.)?
___	___	Does the child watch the speaker's face when listening?
___	___	Does the child wear hearing aids?
		Right ear_____ Left ear_____ Both ears_____
		Make and Model_____
		How long have they worn hearing aids?_____
		How many hours a day does your child wear the hearing aids?_____

Speech/Language

1. Did the child begin to babble or talk and then stop? ___yes ___no
   If yes, please explain_____
   _____
   _____

2. Please indicate all means of communication currently used:
   ___Speech ___Vocalizations ___Bodily Gestures
   ___Facial Gestures ___Gestural (yes/no) ___Takes to item physically
   ___Spoken (yes/no) ___Manual Signs ___Pointing
   ___Augmentative Communication Device ___Photographs/pictures
   ___Other communicative behaviors such as crying, smiling, screaming, physical behavior (e.g. hitting or dropping to the ground)

List any adaptive equipment or alternative augmentative communication modalities (e.g. PECS, signs, speech generating device, iPad app, etc.) that have previously or are currently used:

_____ _____ _____
_____ _____ _____

3. Did your child say their first word around one year of age and start speaking in +3-4 words sentences by age 3? Yes: ___ If not, explain:_____

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

5. How often does your child use speech? ___Frequently ___Sometimes ___Rarely

6. Does the child use gestures often? ___yes ___no if so, give an example_____
_____

7. What does the child use the most?
___Gestures ___Sounds ___One or two words ___Phrases ___Complete sentences

8. What do they typically communicate about?
Requesting_____ Protesting_____Commenting_____
Asking questions_____ Answering questions_____Humor_____Other:_____

9. Estimate the percentage of time that the child is understood by:
___Unfamiliar listeners ___Parents ___Other adults ___Brothers and Sisters ___Friends

10. How well does the child understand what is said to them?_____

11. Please indicate the child's current level of understanding by checking those that apply:
___Understands gestures
___Does not understand spoken words
___Understands single words
___Understands simple sentences
___Understands 2 and 3 part commands
___Understands conversation

12. Do you think the child is aware of their communication difference? ___yes ___no
If yes, please describe how the child shows awareness. _____
_____
_____

13. Provide any other information about your child's communication that is of concern to you.
_____
_____

14. What have immediate family and/or relatives done to help the child overcome the communication difficulty of your child? Has this helped?
_____
_____

15. What do you think caused this communication difference?_____
_____
_____

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

IV. Adoption/ Foster Care

****Any information about the birth family history should be added in sections V and IX.**

1. Is your child in foster care?_____ Starting when?_____
2. Is your child adopted? ___yes ___no If yes, at what age was the child adopted?_____
3. Was it a domestic or international adoption? _____
4. If international, what country were they adopted from? _____
5. If international, were they in an orphanage or foster home before adoption? _____

V. Prenatal (pregnancy), Birth, and Development

1. **Prenatal**

Parent's age when child was born_____ Parent's age when child was born_____
Length of pregnancy in weeks_____

Yes	No	
___	___	Did the biological mother experience bleeding during pregnancy?
___	___	Did the biological mother have measles during pregnancy?
___	___	Did the biological mother have high blood pressure during pregnancy?
___	___	Did the biological mother experience leakage of membranes during pregnancy?
___	___	Were there complications during this pregnancy? (anemia, dehydration, diabetes, kidney infection, severe nausea, toxemia, accidents, other) If so, please describe condition and medical attention received_____ _____
___	___	Were prescription/non-prescription drugs (including alcohol) taken during pregnancy? If so, please list_____

2. **Birth**

Yes	No	
___	___	Did the biological mother have a normal delivery with this child?
___	___	Breech delivery?
___	___	Caesarean Section delivery?
___	___	Were there birth injuries? Please describe_____
___	___	Breathing difficulties (e.g., blue baby, required oxygen, stopped breathing, apnea, other_____)
___	___	Special instruments used during delivery?
___	___	Please describe_____
___	___	Was the baby jaundiced at birth?
___	___	Rh incompatible?

Birth weight_____

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

Were there any problems or complications following birth or delivery for the infant's birth parent? _____

How long was the infant's stay in the hospital following birth?_____

3. **Development** (please mark any of these milestones that did not happen, were delayed or concerning)

_____Held head up	_____Reached for object	_____Crawled
_____Sat up unsupported	_____Stood alone	_____Walked alone
_____Fed self with spoon	_____Bladder Trained	_____Bowel trained
_____Dressed Self	_____Undressed Self	
_____ Other (please describe)		

Would you describe your child's coordination as: _____good _____fair _____poor

VI. Child's Medical History

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

General

___allergies	___asthma	___blood disease
___chicken pox	___convulsions	___crossed eyes
___croup	___dental problems	___diphtheria
___encephalitis	___epilepsy/seizures	___apraxia
___headaches	___head injury	___dysarthria
___heart problems	___high fevers	___influenza
___measles	___meningitis	___mumps
___muscle disorder	___nerve disorder	___traumatic brain injury
___pneumonia	___polio	___bronchopulmonary dysplasia
___rheumatic fever	___cerebral palsy	___tracheostomy
___whooping cough	___stroke	___RSV
___CHARGE association	___Failure to Thrive	___CMV (Cytomegalovirus)
___Feeding or swallowing problems	___HIV	___Gastroesophageal reflux
	___Fetal Alcohol Syndrome	___Neonatal Drug Dependence
___Other:_____	___Concussion	

ALLERGIES

MY CHILD IS ALLERGIC AND/OR HAS ADVERSE REACTIONS TO THE FOLLOWING:_____
_____

Visual

1. Does your child wear glasses? ___yes ___no
2. Does your child have any visual problems? ___yes ___no If so, describe:_____

_____

_____

3. Date of most recent vision testing_____
4. Where was the testing done?_____
5. By whom was the testing performed?_____

Ear, Nose, and Throat

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

___chronic cough/colds	___hoarse voice	___difficulty swallowing
___tonsillitis	___tonsillectomy	___adenoidectomy
___tongue deformity	___jaw deformity	___cleft palate/lip
___speech problem	___ear deformity	___dizziness
___too much wax in ears	___pressure equalization tubes	

Please list any medications the child is presently taking:

_____

If your child has been seen by a medical specialist, physical therapist, speech-language pathologist, occupational therapist, behaviorist, etc., please list below:

Agency/Specialist_____ Date_____
What was done_____
Results/Recommendation/Diagnosis_____

Agency/Specialist_____ Date_____
What was done_____
Results/Recommendation/Diagnosis_____

Agency/Specialist_____ Date_____
What was done_____
Results/Recommendation/Diagnosis_____

VII. Educational and Work History

Name of School_____ Current Grade_____
Class Placement_____
Address_____Phone_____
City_____County_____State_____Zip_____
Teacher's Name_____
Name of Speech Language Pathologist_____
Name of Principal_____

Previous Schools/Child Care Attended:

Name of School/Child Care	Address	Dates Attended
1._____	_____	_____
_____	_____	
2._____	_____	_____
_____	_____	
3._____	_____	_____
_____	_____	_____

Does your child have challenges in any of these areas:
Reading_____ Language_____ Spelling_____ Math_____

Does your child have a current IEP? ___Yes ___No

If yes, please have the school send a copy to this center.

Adolescent Work Section
Employer/ Job Title: _____

Responsibilities: _____

Any challenges with these responsibilities: _____

VIII. Cognitive History
Psychological Evaluation Completed: _____
Date of most recent test: _____Where tested: _____
By Whom? _____Test Results:_____
_____
*Please provide us with a copy of this Evaluation Report.

IX. Home and Family
Please list other family member(s) who have a hearing loss (before age 50) or speech/language or learning difficulties (siblings, parents, and extended family such as grandparents, cousins, etc.):

Name	Date of Birth	Age	Communication/ Learning Concern	Relation to This Child
_____	_____	___	_____	_____
_____	_____	___	_____	_____

Please list everyone who lives with this child (i.e., siblings, grandparents):

Name	Age	Relationship to this child

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

Signature of Parent/Guardian_____

Date_____