Delaware Speech and Hearing Center
COMMUNICATION FOR A LIFETIME

☐ 494 W Central Ave; Delaware, OH 43015 ☐ 3940 N Hampton Drive; Powell, OH 43065

CASE HISTORY INFORMATION (R) 9/2017

Please complete and bring the enclosed forms, insurance cards, and applicable copay with you at the time of your child's testing. Your appointment is for _____ at _____Please call 740-369-3650 **IN ADVANCE** with any questions or to cancel.

Child's Name: _____ Birthdate: _____ Age: _____

Address: _____

City _____ Zip _____ County _____

Mother's Name: _____Birthdate: _____Occupation: _____

Address: _____City _____Zip_____

(H) Phone: _____ (W) Phone _____ (Cell) _____

(H) Ok to leave message ☐ (W) Ok to leave message ☐ (Cell) Ok to leave message ☐

Employer: _____ Email Address: _____

Father's Name: _____Birthdate: _____Occupation: _____

Address: _____City _____Zip_____

(H) Phone: _____ (W) Phone _____ (Cell) _____

☐Ok to leave message ☐Ok to leave message ☐ Ok to leave message

Employer: _____ Email Address: _____

Would you like to receive our newsletter? Yes

Name(s)/Relationship(s) of People Living At Home: _____

_____Person completing form/relationship_____

Physician/Address: _____

Referred By/Address: _____

Child's School/Daycare/Preschool _____

MEDICAL HISTORY: **(If yes, please explain)**

Were there any problems during pregnancy or difficulties at birth? _____

Was your child born a month or more early? _____

Has your child been hospitalized at any time? _____

Has your child had any trouble with eating, sucking, or swallowing? _____

Is there a family history of speech/language/hearing problems? _____

Are there any known educational difficulties? _____

Does your child have any allergies? _____

Has your child had his or her tonsils removed? _____

Has your child had his or her adenoids removed? _____

Is your child presently taking any medications? _____

List any current medical history/ medical diagnosis: _____

HEARING STATUS: **(If yes, please explain)** Does your child:

Talk in a very loud voice? _____

Have a history of ear infections? How many? ____ Date of last one _____

Has your child needed medication for ear infections? _____

Has your child needed tubes? Surgery Date _____

Do you have any concerns about your child's hearing? _____

Has your child had a hearing test? When? _____ Where _____

If yes, any reported hearing loss? Please describe: _____

Does your child have vision problems? _____

UNDERSTANDING LANGUAGE

When you talk to your child, how much does he/she understand? Check One

☐ A few words ☐ Simple directions ☐ Many words ☐ Almost everything I say

Additional comments/examples _____

COMMUNICATION/DEVELOPMENT HISTORY

How does your child usually let you know what he wants? Check ALL that apply:

☐ Cries ☐ Makes a few sounds ☐ Uses many words, one at a time

☐ Points to what he/she wants ☐ Makes many sounds ☐ Uses long sentences

☐ Uses gestures ☐ Says a few words

Additional comments/examples _____

Does your child: (Yes/No) **(please explain)**

Answer when you talk to him/her? _____

Talk about what he/she is doing? _____

Ask for help? _____

Can the family understand your child's speech? _____

Can people outside the family understand your child? _____

Do you feel your child has difficulty with speech? _____

Do you feel your child has difficulty with language? _____

When did your child FIRST use single words? Age _____ Sentences? Age _____ Walk? Age _____

Please describe your concerns: _____

Who first noticed the problem? _____ When? _____

PLAY AND ADAPTIVE SKILLS

Do you have concern about how your child uses his/her hands (e.g to color/write)? _____

Does your child appear clumsy or uncoordinated? _____

Does your child need excessive amount of help compared to his peers for bathing_____ dressing_____ feeding_____

sleeping_____ playing_____ participating in community_____ family events_____

What are your child's strengths? _____

Do you have any concerns about your child's behavior?_____ Explain?_____

_____

THERAPY/TREATMENT

My child been in enrolled in therapy/treatment before been evaluated before

When? _____ Where? _____

Comments about previous therapy/treatment _____

What is your child's interests/likes? _____

Is your child currently receiving any educational support services or other therapeutic services? Circle all that apply

☐ Speech When _____ Where _____

☐ Occupational Therapy When _____ Where _____

☐ Physical Therapy When _____ Where _____

☐ Counseling/Guidance Counselor When _____ Where _____

☐ Tutor/Resource Room At School When _____ Where _____

☐ Other _____ When _____ Where _____

I would like my child to learn how to _____