Speech & Hearing Center of the Mid-South
DBA Memphis Oral School for the Deaf
Empowering Deaf Children to Listen, Learn, and Talk

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CASE HISTORY FORM-PRESCHOOL

Child's Name _____
First Middle Last

What do you want your child to be called? _____ DOB _____ Sex _____

Address_____ City _____ St _____ Zip _____

Parent/Guardian #1

Name_____ Relationship to child _____

Place of Employment/Occupation_____

Cell Phone _____ Work _____ Home_____

Email address _____

Address (if different from child) _____

Parent/Guardian #2

Name_____ Relationship to child _____

Place of Employment/Occupation_____

Cell Phone _____ Work _____ Home_____

Email address _____

Address (if different from child) _____

FAMILY BACKGROUND INFORMATION

1. List all adults and children who are currently living in your home

Name	Age	Relationship

2. Is there a family history (i.e. parents, siblings, grandparents, etc.) of any of the following?

		Who?			Who?
	Hearing loss			Delayed motor development	
	Speech problem			Malformation of head, neck or ears	
	Seizure disorder			Learning/Educational Difficulties	
	Attention Difficulties			Other:	

3. Is any language other than English spoken in the home? _____ If so, what? _____

4. Please describe any additional family information that would be pertinent to our ability to serve your child.

_____

_____

STATEMENT OF PROBLEM

1. Describe your concerns about your child's development/academic learning.

   _____

2. When did you first notice a problem?

   _____

3. What is your child's awareness of/reaction to this problem?

   _____

4. How do you and other family members react to this problem?

   _____

PRENATAL AND BIRTH HISTORY

1. My child was born at _____ weeks, gestational age, via _____

2. Check any of the factors below that apply to the birth mother's pregnancy

   - ☐ Smoking
   - ☐ Drug use
   - ☐ Diabetes
   - ☐ Premature rupture of membranes
   - ☐ Illness (i.e. German Measles
   - ☐ Induced labor
   - ☐ Alcohol use
   - ☐ Trauma/injuries
   - ☐ High blood pressure
   - ☐ Rh incompatability
   - ☐ Need for hospitalization or bed rest
   - ☐ Excessive weight loss or gain (please indicate)
   - ☐ Other _____

3. Describe any additional complications that occurred during/after your child's birth.

   _____

MEDICAL HISTORY - CHILD

Pediatrician's Name _____ Phone _____

1. Check any of the previous or current health concerns that apply to your child

____ Hearing loss	____ Feeding problems	____ Ear infections	____ Prolonged hospitalization
____ Seizure disorder	____ Vision problems	____ Asthma	____ Educational difficulties
____ Low birth weight	____ Cleft lip or palate	____ Allergies	____ Attention Deficit
____ P.E. tube insertion	____ Malformation of the head, neck or ears		____ Other _____

2. Explain any of the items marked above

   _____

3. Please list your child's current medications

   _____

SPEECH AND LANGUAGE DEVELOPMENT

1. At <u>what age</u> did your child first demonstrate the following:

   Single Words _____ Phrases/Basic Sentences _____ Conversation _____

2. If applicable, describe your child's speech sound errors. _____

3. How well do other people understand your child? _____

4. Describe your child's ability in following directions and answering questions:

   _____

5. Are you concerned about your child's voice? _____ Yes _____ No If yes, please describe.

   _____

6. Are you concerned about your child stuttering? _____ Yes _____ No If yes, please describe.

   _____

SOCIAL/EMOTIONAL DEVELOPMENT

1. Please check all characteristics that best describe your child

☐ Overly active
☐ Overly quiet
☐ Fearful
☐ Destructive
☐ Very Shy
☐ Perfectionist
☐ Happy
☐ Nervous
☐ Dependent
☐ Independent
☐ Even tempered
☐ Good natured
☐ Plays well with other children
☐ Prefers older children
☐ Dependent upon routines
☐ Has difficulty separating from parents
☐ Thumb sucking
☐ Engages in pretend play
☐ Unusual/interrupted eating habits
☐ Unusual/interrupted sleeping habits
☐ Easily controlled/passive
☐ Excessive tantrums
☐ Defiant
☐ Moody
☐ Sensitive
☐ Friendly/Outgoing
☐ Prefers to play alone
☐ Aggressive
☐ Attentive
☐ Clumsy
☐ Impulsive

2. Does your child have difficulty with using appropriate eye contact during conversation? _____ Yes _____ No
3. Does your child have difficulty with "staying on topic" during conversation? _____ Yes _____ No
4. Does your child have difficulty answering questions? _____ Yes _____ No If yes please explain
_____
5. Is your child easily distracted by any of the following:
   Auditory stimuli _____ Yes _____ No Visual stimuli _____ Yes _____ No
   Other people _____ Yes _____ No Nearby activities _____ Yes _____ No
6. List your child's interests _____
7. Please describe any additional concerns about your child's behavior _____
_____

PLAY BEHAVIORS

1. Which of the following describes the type of play your child likes to engage in most often?

	Putting toys in mouth		Shaking toys		Banging toys together
	Using one object for another		Throwing toys		Pushing/pulling toys
	Acting out familiar routines		Role-playing		Make-believe play
	Rough and tumble play		Games with rules		Looking at books
	Appropriate use of objects				

2. Is your child overly attached to a specific toy, object, activity, etc? _____ Yes _____ No If yes please explain
_____
3. What is the average length of time your child can stay playing one activity? _____
4. How long does your child spend watching TV/playing games on electronic devices each day? _____

FEEDING DEVELOPMENT

1. Please check any feeding difficulties that your child has experienced.
_____ Difficulty sucking or nursing
_____ Regurgitation of liquids or solids through nose
_____ Difficulty transitioning from pureed to textured
_____ Difficulty swallowing liquids
_____ History of aspiration/Tube Feeding
_____ Excessive length of time to drink a bottle
_____ Difficulty transitioning from bottle to baby food
_____ Difficulty chewing or swallowing meats
_____ Choking and/or gagging
_____ Reflux
2. Is your child a "picky" eater? _____ Yes _____ No
3. If yes, what foods does your child prefer? _____

4. Does your child prefer/avoid certain food *textures*? _____ Yes _____ No Explain.
   _____
5. Does your child drool more than other children their age? _____ Yes _____ No
6. Did your child have difficulty gaining weight as an infant? _____ Yes _____ No
7. At what age did your child quit using a: Pacifier _____ Bottle _____ "Sippy" cup _____

MOTOR DEVELOPMENT

1. At approximately what age did your child achieve the following milestones?
   _____ Head support _____ Sitting alone _____ Standing alone _____ Walking alone
   _____ Crawling _____ Eating with a spoon _____ Undressing self _____ Potty trained
2. Is your child overly awkward or clumsy? ____ Yes ____ No
3. Does your child show aversion to certain textures (e.g. sticky, rough, wet, etc.)? _____ Yes _____ No
   If yes, give examples _____

THERAPEUTIC HISTORY

1. Please indicate which areas of development your child has received evaluations and/or therapy for in the places below.
   - ☐ Speech problems
   - ☐ Vision problems
   - ☐ Hearing problems
   - ☐ ADD/ADHD
   - ☐ Learning Disabilities
   - ☐ Physical/motor difficulties
   - ☐ Feeding problems
   - ☐ Sensory Integrative Dysfunction
2. If applicable, complete descriptions of services that have been rendered.

Type of therapy/evaluation	Date	Place	Results

3. List any diagnoses that your child has received from a doctor or a qualified healthcare and/or educational professional.
   _____

EDUCATIONAL HISTORY

1. Does your child attend school or daycare? _____ Yes _____ No If yes, list the location, times, and number of days per week _____
2. If applicable, describe the teacher's concerns about your child's performance at school. _____
   _____
3. If applicable, describe your concerns about your child's performance at school . _____
   _____

ADDITIONAL COMMENTS

_____

_____

Signature of person completing this form **Relationship to client** **Date**

By completing this form, I understand that the information in this report is confidential but may be included in my child's reports from the Speech and Hearing Center of the Mid-South DBA Memphis Oral School for the Deaf. These reports will be sent to additional educational and medical providers with your written consent.

Adapted from The Rosetti Pediatric Case History and Family Needs Profile, 1995. Rosetti, L., Kile, J.E., Osborne, C.A., Schaffmayer, M.J., Thomas, S., Williams, B.J., Linguisystems, Inc.

Adapted from SPS, Inc. (n.d.). Pediatric Case History Form. Retrieved September 2, 2004, from http://www.sps.atlanta.com/forms/pediatric-casehistory.pdf