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-DAY SCHOOL

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 _____ Preferred method of communication

Address (if different from child) _____ ☐ Email ☐ Phone

Parent/Guardian #2

Name_____ Relationship to child _____

Place of Employment/Occupation_____

Cell Phone _____ Work _____ Home_____

Email address _____ Preferred method of communication

Address (if different from child) _____ ☐ Email ☐ Phone

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 ☐ vaginal delivery ☐ C-section
2. Check any of the factors below that apply to the birth mother's pregnancy

	Smoking		Premature rupture of membranes		Need for hospitalization or bed rest
	Drug use		Illness (e.g. German measles)		Excessive weight loss or gain (please indicate)
	Alcohol use		Trauma/injuries		
	Diabetes		High blood pressure		Other:
	Induced labor		Rh incompatibility		

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

   _____

MEDICAL HISTORY - CHILD

Pediatrician _____ Phone _____

Otolaryngologist (ENT) _____ Phone _____

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

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

2. Explain any of the items marked above

   _____

3. Please list your child's current medications

   _____

HEARING HISTORY

1. Why did you suspect your child had a hearing problem? When did you notice?

   _____ _____

2. What were the results of your child's newborn hearing screening? _____ Pass _____ Fail
3. Has your child's hearing ever been tested by an audiologist? ____ Yes _____ No Date _____

   Audiologist _____ Location _____ Child's age _____
4. Describe the results of your child's most recent audiological evaluation:
   Type of loss _____ Conductive _____ Sensorineural _____ Mixed Affected ears ____ Left _____ Right

   Severity level _____ (i.e. mild, profound, different severity levels for each ear)

CHILD'S AMPLIFICATION

1. Current audiologist _____ Phone _____
2. What age did your child begin wearing amplification full time? _____

Hearing Aids	Make/Model	Serial Number	Volume Level	Child's Age
Left Hearing Aid	_____	_____	_____	_____
Right Hearing Aid	_____	_____	_____	_____

Cochlear Implant(s)

Doctor's Name _____ Date of Surgery _____ Hospital _____

Name of CI Device _____ Side of CI Device _____ Left _____ Right

CI Activation Date _____ Left _____ Right

Programming Audiologist's Name _____ Phone _____

SPEECH AND LANGUAGE DEVELOPMENT

1. At what age did your child first demonstrate the following:
   Single Words _____ Phrases/Basic Sentences _____ Conversation _____
2. Check the following methods your child uses to communicate their wants and needs:

	Looking at objects		Vocalizing/grunting		Single words
	Crying		Pointing at objects		2-3 word combination
	Gestures		Physical manipulation		Sentences

3. If applicable, describe your child's speech sound errors. _____
4. How well do other people understand your child? _____
5. What do you think your child understands?

	His/her name		Family names		Simple directions
	Names of body parts		Names of objects		Complex directions/conversation

5. Describe your child's ability in following directions and answering questions:
   _____
6. Are you concerned about your child's voice? _____ Yes _____ No If yes, please describe.
   _____
7. 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		Good natured		Plays well with other children
	Overly quiet		Defiant		Dependent upon routines
	Fearful		Moody		Has difficulty separating from parents
	Destructive		Impulsive		Unusual/interrupted eating habits
	Very shy		Aggressive		Unusual/interrupted sleeping habits
	Perfectionist		Attentive		Thumb sucking
	Happy		Excessive tantrums		Engages in pretend play
	Nervous		Friendly/outgoing		Easily controlled/passive
	Dependent		Prefers to play alone		Even tempered
	Independent		Prefers older children		

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. 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. Describe your child's interests: _____
3. Is your child overly attached to a specific toy, object, activity, etc? _____ Yes _____ No If yes please explain

_____

4. Who does your child prefer to play with? _____
5. What is the average length of time your child can stay playing one activity? _____
6. What activity seems to hold your child's attention for the longest period of time? _____
7. What activity seems to hold your child's attention for the shortest period of time? _____
8. How long does your child spend watching TV/playing games on electronic devices each day? _____
9. Describe your child's bedtime routine (including the typical time in which your child goes to bed): _____

_____

FEEDING DEVELOPMENT

1. Please check any feeding difficulties that your child has experienced.

	Difficulty sucking or nursing		Excessive length of time to drink a bottle
	Regurgitation of liquids or solids through nose		Difficulty transitioning from bottle to baby food
	Difficulty transitioning from pureed to textured		Difficulty chewing or swallowing meats
	Difficulty swallowing liquids		Choking and/or gagging
	History of aspiration/tube feeding		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		ADD/ADHD		Feeding problems
	Vision problems		Learning disabilities		Sensory integrative dysfunction
	Hearing problems		Physical/motor difficulties		

2. If applicable, complete descriptions of services that have been rendered.

Type of therapy/evaluation	Date	Place	Results

EDUCATIONAL HISTORY

1. Does your child attend school or daycare? _____ Yes _____ No If applicable, what kind of daycare?
   _____ Child care facility _____ Birth to 3 program _____ Special Needs _____ Regular preschool

   If applicable, please list the location, times, and number of days per week that your child attends.
   _____

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