DELAWARE SPEECH & HEARING CENTER (R) 1/06

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

CASE HISTORY INFORMATION – SPEECH AND LANGUAGE – CHILD (R) 6/2008

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: ____ Male Female

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? Y N Electronic Mail

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 (Circle one) **(If yes, please explain)**

Were there any problems during pregnancy or difficulties at birth?	NO	YES	________________
Was your child born a month or more early?	NO	YES	________________
Has your child been hospitalized at any time?	NO	YES	________________
Has your child had any trouble with eating, sucking, or swallowing?	NO	YES	________________
Is there a family history of speech/language/hearing problems?	NO	YES	________________
Are there any known educational difficulties?	NO	YES	________________
Does your child have any allergies?	NO	YES	________________
Has your child had his or her tonsils removed?	NO	YES	________________
Has your child had his or her adenoids removed?	NO	YES	________________
Is your child presently taking any medications?	NO	YES	________________

Additional comments about your child's medical history/diagnosis: ______________________________

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

Talk in a very loud voice?	NO	YES	________________
Turn up the radio/TV volume?	NO	YES	________________
Have a history of ear infections?	NO	YES	How many? ____ Date of last one _________
Has your child needed medication for ear infections?	NO	YES	________________
Has your child needed tubes?	NO	YES	Surgery Date ________________
Hear you if his/her back is turned?	NO	YES	________________
Hear you from the other room?	NO	YES	________________

Has your child had a hearing test? NO YES When? ________ Where ________________

Additional information about your child's ears/hearing: ____

Does your child have vision problems? NO YES ____

UNDERSTANDING LANGUAGE

When you talk to your child, how much does he/she understand? Circle 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? Circle 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: (Circle one) **(please explain)**

Answer when you talk to him/her?	NO	YES	________________________
Talk about what he/she is doing?	NO	YES	________________________
Ask for help?	NO	YES	________________________
Can the family understand your child's speech?	NO	YES	________________________
Can people outside the family understand your child?	NO	YES	________________________
Do you feel your child has difficulty with speech?	NO	YES	________________________
Do you feel your child has difficulty with language?	NO	YES	________________________

When did your child FIRST use single words? Age ______ Sentences? Age _____________ Walk? Age _______________

Please describe your concerns: ____

____

Who first noticed the problem? ____________________________ When? ____________________________

THERAPY/TREATMENT

My child HAS HAS NOT been in enrolled in therapy/treatment before HAS HAS NOT 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 ____

I would like to have more information about: (Circle all that apply)

Speech and language development	Listing of local preschools programs
Speech and language problems	Hearing