___ 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.
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) __________________________

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

Employer: ____________________________________ Email Address: ______________________________

Would you like to receive our newsletter?

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? ______________________________

Additional comments about your child's medical history/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 ______________

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

Does your child have vision problems? ____

UNDERSTANDING LANGUAGE

When you talk to your child, how much does he/she understand? Select one.

Additional comments/examples ____

COMMUNICATION/DEVELOPMENT HISTORY

How does your child usually let you know what he wants? Select 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: **(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? Select 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 ____