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) 6/2022

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 _____

Parent/Guardian 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: _____

Parent/Guardian 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	_____

List any current medical history/ medical diagnosis: _____

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

Talk in a very loud voice?	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 _____
Do you have any concerns about your child's hearing?	NO	YES	_____
Has your child had a hearing test?	NO	YES	When? _____ Where _____

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

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? _____

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 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 _____