Please check one: Hearing Eval\_\_\_\_\_

 Diagnostic:\_\_\_\_\_\_\_\_\_\_\_

 Speech Therapy:\_\_\_\_\_\_

Texas State University-San Marcos

Speech, Language and Hearing Clinic

601 University Drive

San Marcos, TX 78666

(512) 245-8245

 **PLEASE ATTACH ANY REPORTS FROM PREVIOUS AGENCY OR SCHOOLS**

**Child Case History**

**with a Middle Eastern Background**

##### PLEASE PRINT IN INK OR TYPE ALL INFORMATION

**General Information**

######  Today’s Date

###### Child’s Name Date of Birth: Gender

Address: Phone:

City: Zip:

Mother’s Name: Age:

Mother’s Occupation: Business Phone:

Father’s Name: Age:

Father’s Occupation: Business Phone:

Does the child live with both parents?

If no, with whom does the child live?

Brothers and Sisters (include names and ages):

Referred By: Phone:

Address:

Physician: Phone:

Address:

**Office Use Only:**

**Date Received:**

**Dates Contacted:**

Other specialists who have seen the child:

**Please attach the most recent report for the Doctor, agency or school listed above.**

Address: Phone:

What were the other specialists’ conclusions and/or recommendations?

How many family members live in the household? Please list the brothers and sister (if any) and their ages.

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Who is the primary caregiver and who else participates in the caregiving? What language do they use?

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What language (s) does the child speak?

If the child speaks more than one language, which one was first acquired or were they acquired at the same time? ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the child’s language proficiency in each language:

 Language Type Familiar listeners Unfamiliar listeners

1st language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_% \_\_\_\_%

2nd language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_% \_\_\_\_%

3rd language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_% \_\_\_\_%

4th language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_% \_\_\_\_%

How does the child usually communicate?

 Gestures Sign Language Single Words Short Phrases Sentences

Describe the child’s speech-language or hearing problem.

When was the problem first noticed?

Who first noticed the problem?

What do you think may have caused the problem?

Since you first noticed the problem, what changes have you observed in your child’s speech, language, or hearing?

Is the child aware of the problem? If yes, how does he or she feel about it?

What have you done to help your child with the problem?

Describe other speech, language, or hearing problems in the family.

What is your child’s religion? ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your family continue any cultural traditions? If so, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any religious or cultural issues that we should be aware of regarding the child’s evaluation? \_\_\_\_\_\_\_

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Does your family follow the lunar calendar? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require your child to participate in the Ramadan? If so, during what periods of the month? ­­­­­­­­\_\_\_\_\_\_\_\_\_\_

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If your child qualifies for speech or language therapy services, do you have a preference on the sex of the clinician? If so, which sex do you prefer? ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list food products your child is allergic to, or that is not allowed in your child’s diet for religious purposes. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prenatal and Birth History**

Describe mother’s general health during pregnancy (illnesses, accidents, prescription and non-prescription medications, etc.).

Length of pregnancy: Length of labor:

Child’s general condition: Birth weight:

Circle type of delivery: head first feet first breech Cesarean

Were forceps used?

Child’s length of stay in hospital:

Describe any unusual conditions that may have affected the pregnancy or birth.

**Medical History**

Child’s general health is: Good Fair Poor

Provide the approximate ages at which the child experienced the following illnesses and conditions.

Adenoidectomy Asthma Allergies

Chicken pox Colds Convulsions

Croup Draining ear Dizziness

Ear infections Epilepsy Encephalitis

German measles Headaches Hearing loss

Heart problems High fever Influenza

Measles Mastoiditis Meningitis

Mumps Noise Exposure Pneumonia

Seizures Sinusitis Tinnitus

Tonsillitis Tonsillectomy Visual Problems

Other Glasses

List child’s current medications.

Describe any major accidents, surgeries, or hospitalizations the child has had.

**Developmental History**

Write the approximate age when the child began to do the following.

Crawl Sit Stand Walk Feed Self

Dress Self Use toilet Use single words Combine words

Name simple objects Use simple questions Engage in a conversation

Does the child have any motor difficulty, such as walking, running, or participating in other activities

 which require small or large muscle coordination?

Describe any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.) your

child has had.

Does the child:

Respond to any sounds?

Respond to the sound of the telephone bell?

Respond to the sound of human voices?

Respond to loud sounds only?

Respond to sounds inconsistently?

Seem to ignore sounds willfully?

Do you suspect any problems with hearing?

**General Behavior**

Does the child eat well? Sleep well?

How does the child interact with other family members?

Is the child: attentive extremely active restless

Does the child bang his/her head, rock, or spin?

Does the child play by him/herself?

How does the child interact with other children?

Does the child lose his/her temper?

With whom does the child spend most of the day?

**Educational History**

School or Preschool: Grade:

Teacher (s):

Describe any special services your child receives.

If enrolled for special education services, list main goals of the Individualized Educational Plan (IEP) or Individual Family Service Plan (IFSP).

Which language(s) is the child exposed to in the school setting? If more than one, which one is practiced majority of the time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What religion is followed in the school curriculum? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please add any additional information you feel might be helpful in the evaluation or treatment of the child’s problem.

Person completing the form:

Relationship to the child:

Signed: Date:

**PLEASE ATTACH ANY REPORT YOU HAVE FROM ANOTHER AGENCY, SCHOOL OR DOCTOR.**

(2006). Speech language & hearing clinic application & process forms. Retrieved May 27, 2009, from Department of communicative disorders and deaf studies Web site: <http://www.csufresno.edu/chhs/depts_programs/comm_disorders_deaf_stud/policies_forms/speech_hearing.shtml>