ANDERSON-OCONEE
SPEECH & HEARING CLINIC

CHILD'S CASE HISTORY FORM

FULL NAME:_____ **DATE:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**____ **ZIP:**_____

HOME PH: (_____) _____ **CELL PH:** (_____) _____ **E-MAIL:**_____

BIRTHDATE:_____ **AGE:**_____ **GENDER: Male / Female RACE: W / B / H /OTHER**

SCHOOL / PRE-K:_____ **GRADE:**_____

Father:_____ **Mother:**_____

Employed by:_____ **Employed by:**_____

Education:_____ **Education:**_____

Other children in the family and their ages:_____

Other family members with speech or hearing problems:_____

Who referred you to our clinic?_____

Family doctor or pediatrician:_____

Did your child pass the newborn hearing screening at the hospital? Yes / No

Has your child ever had a speech evaluation? Yes / No Or hearing evaluation? Yes / No

If YES, where?_____

Has or is your child receiving any of the following therapies?

Speech Therapy:	**Yes / No**
Physical Therapy:	**Yes / No**
Occupational Therapy:	**Yes / No**
Behavioral Therapy:	**Yes / No**

Other specialists or agencies that have seen or evaluated your child:_____

_____

List any medications your child is currently taking, along with dose and frequency:_____

_____

List any allergies:_____

MORE INFORMATION IS NEEDED ON BACK

Does your child see a dentist on a regular basis?_____Date of last dental appointment:_____

Describe your child's problem as it appears to you:_____

_____

BIRTH AND MECICAL HISTORY

Age of mother at pregnancy:_____During pregnancy, did mother experience any unusual illness, condition, accident, German measles, etc.?_____

Length of pregnancy:_____Duration of labor:_____Were there any complications during pregnancy, labor, or delivery?_____

Birth weight:_____Instruments used:_____Was baby blue, jaundiced, or have any condition worth noting?_____

List any diseases, injuries or hospitalizations of the child with age of occurrence:_____

_____

DEVELOPMENTAL HISTORY

Did child's rate of development seem normal to you?_____When did child first hold up head alone?_____Crawl:_____Sit alone without support:_____Were there any concerns about child's development?_____

Describe child's history of ear infections (frequency, first occurrence, most recent, treatment):

_____

Has your child ever had ear tubes?_____If YES, when?_____

If you suspect a hearing problem, please describe:_____

_____

Please include any additional information which has not been included that may help in the evaluation and treatment of your child:_____

_____

_____

Parent or guardian signature:_____Date:_____