CONFIDENTIAL

Princeton Speech-Language & Learning Center

HEARING PEDIATRIC CASE HISTORY FORM

The information you provide on this form will give us a better understanding of your child and expedite the course of the speech and language evaluation process. All material and information is strictly confidential.

Date: _____

Person completing this form: _____

Relationship to child (parent, teacher, etc): _____

What information do you hope to obtain from this evaluation? _____

_____

General Information

CHILD'S NAME:_____ School & grade:_____

Date of Birth: _____ Age: _____

Address:_____ Phone:_____

_____

County: _____

E-mail address: _____

MOTHER'S NAME:_____ Cell phone:_____

Mother's occupation:_____ Business phone:_____

FATHER'S NAME:_____ Cell phone:_____

Father's occupation:_____ Business phone:_____

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Does your child live with both parents?_____
With whom does your child spend most of his/her time during the week? _____

Relationship to child? _____

Referred by:_____ Phone:_____

Pediatrician/Primary Doctor:_____ Phone:_____

Address:
_____

Audiologist: _____ Phone: _____

Address:
_____

Please list other professionals currently involved with your child's care (Psychologist, Neurologist, Speech Language Pathologist, Occupational Therapist, Ear Nose Throat Doctor, tutors etc.) _____

Phone:_____

Address:_____

Siblings (include names and ages):_____

Is English your child's primary language? Y / N

If no, what other languages does the child speak?

Have any other speech-language or hearing specialists seen your child? Who and when?

Was your child ever evaluated for early intervention or by a child study team?

Please indicate date administered and results of the following (if applicable):
Vision Testing:
Developmental testing:

Are there any other hearing, speech, language, learning, reading, or attention problems in your family? If yes, please describe.

Hearing Loss Information

Date of Identification: _____

Time of Onset (please circle):

Birth	2nd-3rd year of life	If known specifically:
First year of life	3 years or older	_____

Etiology: _____

Please Circle:

Unilateral loss	Sensorineural	Mild
Bilateral loss	Conductive	Moderate
	Mixed	Severe
		Profound

If available, please indicate hearing thresholds at the following frequencies:

500	1000	2000	4000

Aided speech reception threshold: _____

Amplification Information

Date of Amplification: _____ Wears amplification during all waking hours? Y/ N

Cochlear Implant: Y / N

Side: R / L / bilateral

Make/model:_____

Processing Strategy: _____

Implant Center: _____

Date of Activation: _____

Personal FM system? Y / N

Hearing Aid(s): Y / N

Side: R / L / bilateral

Make/model:_____

Personal FM system? Y / N

Make/Model:_____

Does your child use a sound field system at school? Y / N

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.):

Please describe any complications during pregnancy/delivery:

Medical History

Please list at what age your child had any of the following conditions (if applicable):

Allergies (type):	Asthma:	Dizziness:
Ear infections:	Frequent Colds: (More than 6 per year)	
Headaches:	High fever:	Influenza:
Seizures:	Sinusitis:	Tonsillitis:
ADD/ADHD:	Snores:	Other:

Has your child had any surgeries? If yes, what type and when (e.g., tonsillectomy, adenoidectomy, etc.)?

Is your child up to date on their vaccines? Yes/No

Describe any major accidents or hospitalizations:

Is your child taking any medications? If yes, please list.

Have there been any negative reactions to medications? If yes, identify.

Has your child been given a specific medical diagnosis? If so, what and by whom?

Developmental History

Provide the approximate age at which your child began to do the following activities:

Crawl: Sit: Walk:

Feed self: Use toilet:

Use single words: (e.g., no, mom, doggie, etc.):

Name simple objects (e.g., dog, car, tree, etc.):

Combine words (e.g., me go, daddy shoe, etc.):

Engage in conversation:

Does/Did your child ever use a pacifier/suck thumb or have an attachment to any other objects they put in their mouth? yes/no

If yes, how often and under what conditions?
If no, not currently or never had?

How does your child primarily communicate (gestures, single words, short phrases, sentences, conversation)?

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Are there or have there been any feeding or eating problems (e.g., any problems with sucking, tolerating specific food textures, swallowing, drooling, chewing, etc.)? If yes, please describe.

From what does your child primarily drink? (e.g. cup, straw, sippy cup, bottle)

Educational History

If preschool, how may days/week, full/half days? Self contained program or inclusive program?

If applicable, does your child sit through circle time?

Has his/her teacher reported any concerns to you?

Have you reported any concerns to the teacher?

How is your child doing academically (or pre-academically)? Please comment on reading and written language. Does your child like school?

Does your child enjoy reading?
Does your child enjoy being read to?

Does your child receive special services? Is he/she classified? If yes, please describe.

If your child is of school age, how would you describe his/her handwriting (neat, sloppy, average)?

Social History

How does your child interact with others (e.g., shy, aggressive, uncooperative, etc.)?

Does the child make friends easily? Yes/No

Does your child have more success interacting with adults than peers? Yes/No

Has your child shown any social difficulties related to his/her hearing aids/cochlear implant/ FM system?

Do you have any concerns about your child's social skills or ability to make/keep friends?

Provide any additional information that might be helpful in the evaluation or treatment of your child's communication:

Princeton Speech-Language & Learning Center

Financial Responsibility

I hereby agree to accept full responsibility for all fees for service rendered to the patient by the practitioner.

Signed: _____ Date: _____

Drivers License #: NJ – _____

Cancellation Policy

Princeton Speech and Language Center is dedicated to providing quality services to our clients. We must stress that consistency of attendance is crucial in order for clients to effectively meet the goals of their treatment plan. In addition, therapy time is specifically reserved for your family and is unavailable for other clients.

We are sensitive to the needs faced by the families of our clients however; it is necessary for us to enforce a cancellation policy. Except in cases of emergency or sudden illness, appointments not cancelled **48 hours** in advance will result in a charge as though the appointment was held.

We look forward to a positive relationship with you, as we strive to provide cutting edge, quality treatment and specialized programs. Thank you for your attention to this matter.

Signed: _____ **Date:** _____

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CLINICAL RELEASE OF INFORMATION

Mr.
Mrs.
I, Ms. _____, hereby give Princeton Speech-Language & Learning Center permission to discuss my/my child's case with the interdisciplinary professionals involved in his/her care, and to release any relevant clinical information to those professionals if requested. I also authorize PSLLC to release and/or share any information requested by my insurance company.

_____
(Client's Name)

Please list the professionals to which we may correspond:

Name: _____

Address: _____

_____
_____

Phone: _____
_____

Name: _____

Address: _____

Phone:

Signature of Patient: _____ Date:
_____
Document must be signed by parent or guardian if patient is under 18 years of age.

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In order to assist the speech-pathologist get a complete profile of your child's strengths and weaknesses, please check off any areas which you feel may apply:

Auditory Processing:

_____ Does not listen carefully to directions- often need to repeat instructions.
_____ Sometimes misunderstands what is said.
_____ Needs extra time to respond to questions.
_____ Background noise makes following verbal instructions even more difficult.
_____ Says "huh" or "what" in response to questions.
_____ Does not respond to name when called.

Attention:

_____Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
_____ Often has difficulty sustaining attention in tasks or play activities in school and at home.
_____ Has difficulty organizing tasks and activities.
_____ Often loses things necessary for tasks and activities (e.g., toys, school assignments, pencils, books, or tools.
_____ Fidgets with hands or feet or squirms in seat.
_____ Leaves seat in classroom or in other situations in which remaining seated is expected.
_____ Easily distracted.
_____ Often blurts our answers before the questions have been completed.
_____ Has difficulty awaiting turn.
_____ Daydreams and/or is inattentive.

Word Retrieval:

_____ Knows the word (s)he wants to say, but cannot think of it.
_____ Has difficulty remembering the names of people, places, objects that (s)he knows.
_____ Substitutes words with a similar word or by describing the word by category, function, or what it looks like.
_____ There is sometimes a long delay when (s)he cannot think of the word.
_____ Makes false starts and revisions when relating an experience (e.g., "we were…Bob and I went to the game.").
_____ Uses time fillers when trying to think of a word (e.g., um…er…um…computer).

Sensory Sensitivities:

_____ Expresses distress during grooming (e.g., haircuts, face washing, teeth brushing, nail cutting).
_____ Reacts emotionally or aggressively to touch.
_____ Avoids certain tastes or food smells that are typically part of children's diets.
_____ Picky eater, especially regarding food textures.
_____ Becomes anxious or distressed when feet leave the ground.
_____ Touches people and objects
_____ Doesn't seem to notice when face or hands are messy (e.g., with food, drool, mucous, etc.)

Social Communication:

_____ Decreased eye contact when interacting with others.
_____ Frequent conflicts with peers are noted by others such as teachers, scout leaders, etc.
_____ Avoids or shows no/little interest in social interactions of same age peers, such as birthday parties.
_____ Needs to be directly taught "implied social rules," such as keeping personal space, responding to others when they talk or greet them, how to talk to adults/authority figures vs. peers, messages sent by their tone of voice.
_____ Needs to be frequently given alternate solutions to conflict situations with peers- cannot generate these solutions, or only generates ineffective solutions on their own.