THE UNIVERSITY OF SOUTHERN MISSISSIPPI

SCHOOL OF SPEECH AND HEARING SCIENCES
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APPLICATION FOR ASSESSMENT

Child Case History – Speech/Language Date: _____

Please complete this form in order for our clinical faculty to plan a thorough assessment. It is important that you answer each applicable question as completely and accurately as possible. Please return this form to the Speech-Language Pathology Clinic at the above address so we can schedule your appointment.

GENERAL INFORMATION:

Child's Name: _____ DOB: _____ Gender: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Email:_____ DOB: _____

Occupation: _____ Employer: _____ Phone: _____

Parent/Guardian: _____ Email: _____ DOB: _____

Occupation: _____ Employer: _____ Phone: _____

Address if different from child: _____

Form completed by: _____ Are you the biological parent? _____

If not, explain: _____

Primary language spoken in the home: _____

Referred to this clinic by: _____ Phone: _____

Family Physician: _____ Phone: _____

Additional Children in the home:

Name	Age	Gender	Grade	Speech, Hearing, Medical Problems
_____				
_____				
_____				

STATEMENT OF THE PROBLEM:

Describe concerns about your child's communication skills (fluency, articulation, language, voice).

_____

_____

When was the problem first noticed? _____

By whom? _____ What do you think caused it? _____

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

_____

_____

MEDICAL/BIRTH HISTORY:

Describe mother's general health during pregnancy (illnesses, accidents, medications):

_____

_____

Any problems at birth or during first 2 weeks (jaundice, anoxia, weight, etc.):

_____

_____

Provide approximate age for the following illnesses, operations, conditions or diagnoses?

Earaches: _____
Seizures: _____
Chronic colds: _____
Head injuries: _____
Chicken Pox: _____
Pneumonia: _____
Influenza: _____
Headaches: _____

Asthma: _____
Tonsillitis: _____
Tonsillectomy: _____
Adenoidectomy: _____
Cleft Palate: _____
ADHD: _____
Meningitis: _____
Sinus Problems: _____

List any surgeries, hospitalizations or accidents:_____

_____

List any medications taken by your child: _____

_____

What is the child's current health status? _____

_____

Does child have any medically diagnosed conditions? _____

DEVELOPMENTAL MILESTONES:
Provide age for the following:

Rolled over: _____ Weaned: _____ Sat without support: _____

Toilet trained: _____ Crawled: _____ Spoon-fed self: _____

Walked unaided: _____ Dressed self: _____

Does your child have difficulty chewing or swallowing: _____

EDUCATIONAL HISTORY:

School: _____ Grade: _____Does child receive special services _____

Speech Pathologist: _____

What are the average grades: Math: _____Reading: _____Spelling: _____Language: _____

Repeat or Skip grade level: _____ Did child attend headstart/prek/daycare _____

DAILY BEHAVIOR:

Does child have sleeping problems? (Explain) _____

Eating problems? (Explain) _____

Difficulty concentrating? _____

Difficulty with change? _____

How does child interact with others? _____

_____

Describe the child's favorite play activities: _____

_____

Describe any atypical behavior: _____

_____

SPEECH-LANGUAGE HISTORY:

Did your child babble and coo during the first six months? _____

Age of first meaningful words: _____ Did child continue adding words? _____

When did child put/use two words together? _____

Did speech learning ever seem to stop for a period? _____

Has there been a change in speech in the last six months? (Describe) _____

_____

How many words are presently in the child's vocabulary? Under 25 _____ 25-50 _____ Over 50 _____

Does child use speech frequently? _____ Is child aware of speech difference? _____

Does child prefer to communicate with gestures? _____ sounds? _____

1 or 2 words? _____ phrases? _____ conversation? _____

How well is the speech understood by parents? _____ siblings? _____

playmates? _____ others? _____

What is child's reaction to their speech? _____

HEARING:

Does/did child look at family members when they are named? _____

Does/did child point to common objects when asked "Show me the _____?" or "Where is the _____?

Describe: _____

Does child follow multi step directions?: _____

PLEASE CHECK THE APPROPIATE COLUMN UNDER "YES" OR "NO":	YES	NO
Generally indifferent to sound:	( )	( )
Lack of response when spoken to:	( )	( )
Responds to noise, not voice:	( )	( )
Turns devices too loud, talks too loud or too soft:	( )	( )

Do you think child hears adequately? _____ If not, describe? _____

_____

ENVIRONMENTAL BACKGROUND:

Please list any familial medical/education concerns: birth defects, difficulty in school, reading problems, intellectual disability, mental illness, learning disabilities, cerebral palsy, neurological disorders/seizures, speech disorders, vision problems? Please describe below:

_____

_____

PREVIOUS ASSESSMENTS:
Please bring copies of all reports or IEPs

Has your child received any of the following assessments? Please indicate:

_____ Hearing _____ Speech and Language _____ Psychological _____ Neurological

_____ Occupational Therapy _____ Physical Therapy _____ Vision _____ Developmental

If so, please state when the assessment was conducted, by whom and for what reason:

Type of Exam	Date	By Whom	Reason for Exam

_____

_____

If we have permission to request these reports, please sign here.

Signature: _____ Date: _____

Please provide any additional information that might be helpful in the assessment of your child:

_____

_____

How do you expect the USM Speech-Language Pathology Clinic to help your child? _____

_____