



SPEECH-LANGUAGE-HEARING CENTER

Child Case History Form (Confidential)

Please complete this form and return to the above address. This information will help in planning an evaluation and/or treatment. Please send any speech-language-hearing reports, including Individualized Education Programs, from previous agencies with this case history form. Once we have received requested reports, an evaluation/treatment will be scheduled as soon as an opening becomes available.

Personal Information

Child's Name: _____ Date of Birth: _____ Age: _____ Sex: _____ Date: _____

Address: _____
(# Street)

City _____ State _____ Zip Code _____

With whom does the child live? Both parents Mother Father Other _____

Mother's Name: _____ Address: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____ Fax: _____

Mother's Occupation: _____

Father's Name: _____ Address: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____ Fax: _____

Father's Occupation: _____

Is either parent a Worcester State University employee? Yes No

Name of person giving information: _____ Relationship to child: _____

Referred by: _____

Reason for referral: _____

Has the child been evaluated or treated at this Center before? Yes No

If yes, when and for what reason? _____

Person responsible for payment of fees: _____

Preferred method of communication: Email Phone

Family Information

Siblings' names and ages: _____

Other persons living in the child's home and their relationship to the child: _____

Medical Information

General health is: Good Fair Poor

Please indicate whether or not the child has had any of the following illnesses or conditions:

Accidents	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Adenoidectomy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Head Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hospitalization	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Attention Deficit Disorder (with or without hyperactivity)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Autism	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Meningitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Behavioral Difficulties	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mumps	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bipolar Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Neurological	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer/Tumor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Noise Exposure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cerebral Palsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Paralysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chicken Pox	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pneumonia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cleft Palate	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Psychiatric Diagnosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Concussion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Scarlet Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinusitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Down Syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ear Infections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Swallowing Difficulty	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emotional Difficulties	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid Problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Encephalitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tonsillectomy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tonsillitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fainting Spells	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Feeding Difficulty	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Vision Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fetal Alcohol Syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Voice Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent Colds	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Whooping Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you answered yes to any of the above items, please explain in detail: _____

Please describe any other medical conditions the child may have that are not listed above: _____

Are the child's immunizations current? Yes No

If no, please explain: _____

Current Medications (prescribed, over the counter, herbal): _____

Pediatrician's Name: _____

Address: _____ Phone Number: _____

Dentist's Name: _____

Address: _____ Phone Number: _____

Developmental History

Prenatal and Birth History

Mother's general health during pregnancy Good Fair Poor

Describe any complications during pregnancy (illness, accidents, medications, premature birth, etc.): _____

Were there any noteworthy problems with the infant at birth (e.g., require oxygen, blue at birth, jaundiced, etc.)

Yes No

If yes, please explain: _____

Birth Weight: _____ Apgar Score: _____

Were there any problems immediately following birth or during the first two weeks of the infant's life (health, swallowing, sucking, feeding, sleeping, others)? Yes No

Admitted to Neonatal Intensive Care Unit? Yes No

If yes, please explain: _____

General Development

At what age did the following occur?

Held head erect when lying on stomach: _____

Sat alone: _____

Crawled: _____

Walked unaided: _____

Dressed and undressed self: _____

Fed self with spoon: _____

Was completely toilet trained: _____

What hand does the child prefer to use? Right Left Both

Does the child have difficulty with balance or coordination? Yes No

If yes, please explain: _____

Does the child use any of the following assistance devices:

Wheelchair Walker Glasses Other _____

Speech-Language-Hearing History

Hearing

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

Did the child respond to noises as an infant? Yes No

How? _____

Was the child unusually quiet as an infant? Yes No

If yes, please explain: _____

Are there any concerns about the child's hearing? Yes No

If yes, please explain: _____

Has the child's hearing ever been evaluated? Yes No

If yes, when? _____

What were the results? _____

If the child has a documented hearing loss, please answer the following:

In which ear is there a hearing loss? Right Left Both

When was the onset of the child's hearing loss? _____

Was the onset: Sudden Gradual

Has the hearing loss been gradually progressive in nature? Yes No

Does the hearing loss fluctuate from day to day? Yes No

Does the child use any of the following: Hearing Aids Which ear? Right Left Both

Assistive Listening Device Please list: _____

What is the cause of the hearing loss? _____

Does the child experience any ringing ("tinnitus") in his/her ears or head? Yes No

Does the child ever experience dizziness, balance problems, or spinning sensations? Yes No

If yes, please explain: _____

Has the child had "ear tubes" inserted? Yes No

If yes, when? _____

Are the tubes still in place? Yes No

Is the child followed by an otolaryngologist (ENT)? Yes No

If yes, please provide the doctor's name _____

Address: _____ Phone Number: _____

Is the child followed by an audiologist? Yes No

If yes, please provide the audiologist's name _____

Address: _____ Phone Number: _____

Speech-Language

Did the child coo and babble during the first six months? Yes No

At what age did the child say his/her first word? _____ Example: _____

At what age did the child combine words to make sentences? _____

Did the child acquire speech and then slow down or stop talking? Yes No

If yes, please explain: _____

What is the predominant language spoken in the home? _____

What other language(s) does the child speak in other settings (e.g., church, school, social settings)? _____

What language(s) does the child read and write? _____

Describe the child's communication problem: _____

Why are you concerned about the child's communication? _____

What do you think caused the child's communication difficulties? _____

Are there any other family members with communication difficulties? Yes No

If so, list relationship and explain difficulty: _____

Has the child had a speech-language evaluation? Yes No

Speech-language pathologist's name _____

(Please provide a copy of any previous evaluation reports)

Has the child ever attended speech-language therapy? Yes No

Speech-language pathologist's name _____

(Please provide any documentation related to this service, e.g., IEP, progress reports)

How does the child communicate his/her wants and needs? Please check all that apply.

Sounds/vocalizations Single words Sentences Gestures

Facial expressions Writing Sign Language Computerized Voice Output System

Picture Communication Board/Book Does not communicate wants/needs

Please provide any other information about your child's communication: _____

Please check one for each.

How well can the child be understood by:

	All of the Time	Most of the Time	Some of the Time	Rarely
Parents				
Brothers/Sisters				
Other Family Members				
Peers				
Teachers				
Unfamiliar People				

How does the child's voice sound?

too loud too soft too high breathy
too low hoarse nasal

Does the child "get stuck", repeat or stutter on words? Yes No

If yes, please explain: _____

Does the child have difficulty understanding others? Yes No

If yes, please check all that apply: Following directions Listening to others
 Answering questions Other: _____

Please provide any other concerns regarding the child's listening abilities: _____

Is the child aware of his/her speech-language difficulty? Yes No

If yes, please explain: _____

How does the child react when he/she has trouble communicating? _____

Educational/Social History

Current school placement:

Preschool Elementary Middle School
High School Home Schooled Grade: _____

Name of current school placement: _____

Did the child ever repeat a grade? Yes No

If yes, please explain: _____

Did the child ever skip a grade? Yes No

If yes, please explain: _____

Is the child frequently absent from school or tardy? Yes No

If yes, please explain: _____

What are the child's average grades? _____

(Please provide a copy of the child's most current report card).

What are the child's best subjects? _____

What are the child's poorest subjects? _____

How does the child feel about school? _____

What support services does the child receive? Please check all that apply.

Service	In School	Out of School
Physical Therapy		
Occupational Therapy		
Psychological		
Behavior Support		
Special Education		
Tutoring		

Please provide any additional information regarding the child's educational services: _____

Does the child have: an IEP? Yes No

a 504 plan? Yes No

other? Yes No

Please explain: _____

Describe how the child interacts with peers: _____

Describe how the child interacts with adults: _____

Do you have specific concerns about the child's social interactions? Yes No

If yes, please explain: _____

Summary

How would you like us to help? _____

Please provide additional information that you believe might be helpful in the evaluation or remediation process. Please attach additional pages if needed. _____

Signed: _____ Date: _____

How did you hear about our services?

- | | |
|--|--|
| <input type="checkbox"/> Radio | <input type="checkbox"/> Television |
| <input type="checkbox"/> Mailing | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Alumni | <input type="checkbox"/> Health Fair |
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Higher Education Consortium of Central Massachusetts (HECCMA) |
| <input type="checkbox"/> Website | <input type="checkbox"/> WSU Employee |
| <input type="checkbox"/> WSU posting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Senior Presentation | |

Reminder

Before returning this paperwork to Worcester State University Speech-Language-Hearing Center, have you:

Completed this case history in its entirety?

Read and signed the following release forms?

- Authorization for observation, audio/DVD recording, and use of email/text messaging
- Authorization for Release of Information

Contacted other agencies to have them forward reports (see below) to you or directly to the Worcester State University Speech-Language-Hearing Center?

Speech-language evaluation

Neuropsychological evaluation

Hearing evaluation

Report Card

Individualized Educational Program

Progress Reports

504 Accommodation Plan

Other relevant documentation

For additional information, please contact:
Ann T. Veneziano-Korzec, M.S., CCC-SLP
Director
508-929-8055

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

_____ Diagnostic Evaluation
_____ Therapy



WORCESTER
S T A T E
UNIVERSITY

Date Received: _____
(OFFICE USE ONLY)

Name: _____

SPEECH-LANGUAGE-HEARING CENTER

DOB: _____

486 Chandler Street
Worcester, Massachusetts 01602
508-929-8055 • Fax: 508-929-8175

Child Fluency: Addendum to Child Case History Form (confidential)

Please complete this form and return to the above address. This information will help in planning an evaluation and/or treatment. Please send any speech-language-hearing reports from previous agencies with this and the case history form. Once we have received requested reports, an evaluation/treatment will be scheduled as soon as an opening becomes available.

1. Does the child stutter (for example, hesitate, get stuck, prolong or repeat sounds or words)? Yes No

If yes, please describe what happens. _____

2. When was stuttering in the child's speech first noticed? _____ By whom? _____

3. Is the child's speech the same now as when the problem started? Yes No

If no, please describe how it has changed. _____

4. What do you believe caused the child's stuttering? _____

5. How does the child react to his or her stuttering? _____

6. Do you think the child is aware of his/her stuttering? Yes No

If yes, please explain. _____

7. How do you feel about the child's stuttering? _____

8. Have you done anything to help the child when he/she is experiencing difficulty speaking?

Yes No

If yes, please explain. _____

9. How does the child react to your help? _____

10. Has the child ever experienced teasing because of the stuttering? Yes No

11. Is there a family history of stuttering? Yes No

If yes, please describe: _____

12. Does the child use a fluency facilitative device, such as the Speech Easy or Fluency Master?

Yes No

If yes, please explain: _____

13. What are your long-term goals for the child? _____

14. Do you have any other concerns at this time? Yes No

If yes, please describe. _____



Authorization for Observation and Audio/Video Recording

I, _____ consent to the following that I have checked below for _____ (please check all that apply)
(Client's Name)

_____ I consent and authorize the taking of photographs, audio and/or video recording as well as closed circuit televised monitoring of the client specified above (e.g., client and persons associated with the client), by the Worcester State University Speech-Language-Hearing Center (WSU-SLHC). I understand that the WSU-SLHC is an educational facility and therefore consent that the visual and audio displays as described above may be used for educational training or treatment purposes including (please initial all for which you give consent):

- _____ (1) Case managers, undergraduate and graduate students associated with the Worcester State University Communication Sciences & Disorders Department;
- _____ (2) Other professionals, such as speech-language pathologists, audiologists, educators, and administrators,
- _____ (3) Published or professional journals;*
- _____ (4) Professional or educational conferences.*

* Names of participants in the recording will not be disclosed

_____ I consent and authorize the Worcester State University (WSU) Speech-Language-Hearing Center (SLHC) to allow qualified professional personnel and students connected with the WSU Department of Communication Sciences & Disorders and SLHC to observe all clinical activities (e.g., evaluation, therapy, counseling) provided to the client specified above (e.g., client or persons associated with the client) through one-way mirrors or by closed circuit television for professional purposes.

_____ I consent and authorize the person (s) listed below to observe all clinical activities (e.g., evaluation, therapy, counseling) provided to the client specified above (e.g., client or persons associated with the client) through one-way mirrors.

Client or Parent/Legal Guardian

Date

Case Manager

Revised/Fall 2016



486 Chandler Street • Worcester, MA 01602-2597

Speech-Language-Hearing Center • 508-929-8055 • Fax: 508-929-8175

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT'S NAME: _____ DATE OF BIRTH _____

CLIENT'S ADDRESS: _____

I hereby authorize Worcester State University Speech-Language-Hearing Center to:

OBTAIN FROM: NAME OF FACILITY _____

ATTENTION OF: _____

ADDRESS STREET AND NO. _____

CITY/TOWN _____

I hereby authorize Worcester State University Speech-Language-Hearing Center to:

FURNISH TO: NAME OF FACILITY _____

ADDRESS STREET AND NO. _____

CITY/TOWN _____

The following information concerning the above client pertaining to services provided on or about

DATE _____

INFORMATION REQUESTED _____

RESTRICTIONS (if any) _____

Date

Signature of Client

Date

Signature of Parent or Guardian

Relationship to Client