WORCESTER STATE UNIVERSITY
486 Chandler Street
Worcester, Massachusetts 01602
508-929-8055 Fax: 508-929-8175

Date Received: _____
(Office Use Only)

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

Date:_____

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

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:_____

_____

Rev 10/2014

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

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?

- ☐ Radio
- ☐ Mailing
- ☐ Alumni
- ☐ Family/Friend
- ☐ Website
- ☐ WSU posting
- ☐ Senior Presentation
- ☐ Television
- ☐ Newspaper
- ☐ Health Fair
- ☐ Higher Education Consortium of Central Massachusetts (HECCMA)
- ☐ WSU Employee
- ☐ Other:_____

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 ☐
- Hearing evaluation ☐
- Individualized Educational Program ☐
- 504 Accommodation Plan ☐
- Neuropsychological evaluation ☐
- Report Card ☐
- Progress Reports ☐
- 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
State University

SPEECH–LANGUAGE–HEARING CENTER

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

Date Received: _____
(OFFICE USE ONLY)

Name: _____

DOB: _____

Hearing Addendum (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.

Preferred Method of Communication: Email ☐ Phone ☐

History

1. Reason for visit (primary complaint):

_____

2. Have you ever had your hearing evaluated before? No ☐ Yes ☐

When and why? _____

3. Do you have concerns about your hearing? No ☐ Yes ☐

If yes, please check any of the following that are true of your hearing now:

☐ I can hear, but I do not have a clear understanding of what I am hearing.

☐ I have difficulty hearing in one-on-one situations in a quiet environment.

☐ I have difficulty hearing in groups.

☐ I have difficulty hearing with background noise.

☐ I prefer to have the television turned louder than those around me.

☐ I have difficulty hearing on the telephone.

Do you presently use a hearing aid? No ☐ Yes ☐

For how long?_____

4. Have you ever been to an Otolaryngologist (Ear, Nose, and Throat physician)? No ☐ Yes ☐: When and why?

_____

5. Does anyone in your family have a hearing loss? No ☐ Yes ☐: Who?_____

6. Have you ever been exposed to loud sounds? (gunfire, heavy machinery, loud music, etc.) No ☐ Yes ☐

Please explain. _____

7. Please indicate if you have / had any of the following:

☐ Ringing in your ears or head ☐ Buzzing in your ears or head
☐ Fullness or stuffiness in your ears ☐ Pain in your ears
☐ Drainage or discharge from ears ☐ Facial numbness or tingling

8. Do you ever feel dizzy, unsteady, or off-balance (gait problems)? No ☐ Yes ☐

If yes, is your dizziness accompanied by: Nausea No ☐ Yes ☐
Vomiting No ☐ Yes ☐
Noises in ears No ☐ Yes ☐

9. Are you currently on any medication? No ☐ Yes ☐
Please note. _____

10. Have you ever been hospitalized? No ☐ Yes ☐

When and why? _____

_____

11. How would you rate your general health? Poor ☐ Fair ☐ Good ☐ Excellent ☐

12. Please indicate if you have ever taken any of the following medications:

☐ Mycin Antibiotics (e.g. Streptomycin, Kanamycin, Neomycin, Gentamycin, Tobramycin, Amikacin (*aminoglycosides*), Erythromycin, Vancomycin)?

☐ Aspirin (or Aspirin containing products) at least 6-8 per day for extended periods of time?

☐ Non-steroidal anti-inflammatory drugs (Advil, Aleve, Indocin, Motrin, Naprosyn, Nuprin,) at least 6-8 per day extended periods of time?

☐ Quinine or quinine containing products (e.g., Malaria medicine, muscle cramps, excessive intake of tonic water)?

☐ Intravenous Diuretics?

☐ Chemotherapy Agents?

☐ Any other medicine that might affect hearing?

If you answered yes to any of the above medications, please elaborate: _____

WORCESTER STATE UNIVERSITY

Department of Communication Sciences and Disorders
Phone: 508-929-8055
Fax: 508-929-8175

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

WORCESTER State University

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 herby 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