MILLER SPEECH AND HEARING CLINIC
TEXAS CHRISTIAN UNIVERSITY

Mailing Address:
TCU Box 297450
Fort Worth, TX 76129

Street Address:
3305 West Cantey
Fort Worth, TX 76109

Case History (Child)

Date form completed _____

Child's Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

City/State/Zip Code: _____

Father's Name: _____ **Father's Age:** _____

Father's Address: _____ **Occupation:** _____

Father's Home Phone: _____ **Work Phone:** _____

Mother's Name: _____ **Mother's Age:** _____

Mother's Address: _____ **Occupation:** _____

Mother's Home Phone: _____ **Work Phone:** _____

Email Address: _____ **Cell Phone:** _____

Referred By: _____ ***Phone:*** _____

Family Physician: _____ ***Phone:*** _____

Circle the ways we may communicate with you: **Home phone** **Cell phone** **Work phone** **Email**
May we leave messages at: **Home phone** **Cell phone** **Work phone** **Email**

OTHER FAMILY MEMBERS LIVING WITH CHILD:

NAME	AGE	SEX	GRADE	SCHOOL	SPECIAL EDUCATIONAL NEEDS (If yes, please describe)

_____

_____

_____

What language(s) does the child speak? Does your child use sign language? _____

_____

Which language system does your child prefer to use when communicating his or her needs/wants?

_____

_____

What language is spoken most often in the home? What other languages are spoken in the home?

_____

_____

Describe the child's speech, language, and/or hearing problem. _____

_____

_____

_____

How does the child communicate (e.g., gestures, sign language, single words, phrases, sentences)?

_____

_____

_____

At what age were you first concerned about the child's problem? _____

_____

_____

Has the child's problem changed in the last 6 months? If yes, describe _____

_____

_____

Does the child seem to be aware of his/her problem? If yes, what makes you think so? _____

_____

_____

What percent of what your child says can be understood by his/her parents? _____

_____

_____

Is there any history of speech-language-hearing problems in any family members? If yes, describe. _____

_____

_____

Does your child have any other problems or diagnoses that are influencing his/her development? _____

_____

_____

_____

Has the child ever been seen for a speech or hearing evaluation or therapy? If yes, please give date(s), site(s), and results. _____

_____

_____

Has the child ever been seen by any other specialists? If yes, explain: _____

_____

_____

_____

Circle any of the following that describe the behavior of the child:

Nervous or sensitive	**Has no playmates**	**Nightmares**
Prefers to play alone	**Temper tantrums**	**Easily managed**
Overactive	**Overly talkative**	**Cries easily**
Touches, clings to others	**Likes school**	**Slow Learner**
Behavior problem	**Whiney**	**Friendly**
Separates easily from parents	**Enthusiastic**	**Cooperative**

PRENATAL AND BIRTH HISTORY

Describe any unusual illness, condition, or accident during the pregnancy (German measles, Rh Incompatibility, etc. _____

_____

_____

_____

Is there any history of miscarriages? If yes, explain. _____

_____

_____

Was any medication taken during pregnancy? If yes, please describe. _____

_____

Length of pregnancy: _____ Length of Labor: _____ Birth Weight: _____

Describe any problems during the delivery (breech birth, induced labor, etc.) _____

_____

_____

_____

_____

_____

_____

MEDICAL HISORY

Provide the approximate ages at which the child suffered any of the following illnesses or conditions:

Allergies _____	**Asthma _____**	**Bronchitis _____**
Chicken Pox _____	**Colds _____**	**Convulsions _____**
Croup _____	**Dizziness _____**	**Ear Infections _____**
Encephalitis _____	**Flu _____**	**Headaches _____**
High Fever _____	**Mastoiditis _____**	**Measles _____**
Meningitis _____	**Mumps _____**	**Pneumonia _____**
Seizures _____	**Sinusitis _____**	**Sore Throat _____**
Tinnitus _____	**Tonsillitis _____**	**Other _____**

Does the child receive any medications at this time? Please explain. _____

_____

_____

Has the child had any surgeries? If yes, please provide age(s) and description(s). _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DEVELOPMENTAL HISTORY

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

Hold head up _____ **Sit _____**

Stand _____ **Walk _____**

Feed Self _____ **Dress Self _____**

Toilet Training Begun _____ **Toilet Training Ended _____**

Babble _____ **Use of Words _____**

Use Two-Word Phrases _____ **Name Objects _____**

Use Simple Questions _____ **Engage In Conversation _____**

Child's Present Weight _____ **Child's Present Height _____**

Child's physical development has been: **FAST** **NORMAL** **SLOW**

Child's coordination has been: **GOOD** **AVERAGE** **CLUMSY**

Have there ever been any feeding problems? If yes, describe. _____

_____

_____

Describe the child's response to sound (responds to all sounds, response to loud sounds only, etc.) _____

_____

_____

_____

If your child has a hearing loss, please state the type of loss and age of onset. _____

_____

_____

If your child has a hearing loss, please describe any assistive devices (hearing aids, etc.) _____

_____

_____

EDUCATIONAL HISTORY

School: _____ Grade: _____

At what age did the child start kindergarten or grade school? _____

Were any grades repeated? _____

What are the child's strongest subjects? _____

What subjects does the child have difficulty with? _____

How is the child doing academically? _____

_____

_____

Describe the child's overall progress in school? _____

_____

How does the child interact with others? _____

_____

Does your child receive any special services? If yes, describe. _____

_____

_____

_____

_____

_____

_____

_____

_____

Background Information (Optional)

To ensure that the Miller Speech and Hearing Clinic is meeting our commitment to diversity, we ask clients to provide the following information. Providing information is strictly voluntary.

Are you (the client) Hispanic or Latino?
____Yes ____No

Check one or more of the following groups which you (the client) consider yourself to be a member of:

____American Indian of Alaska Native
____Asian
____Black or African American
____Native Hawaiian or Other Pacific Islander

If enrolled for special education services, has an Individualized Education Plan (IEP) been developed? If yes, describe the most important goals and when initial placement began. _____

_____

_____

If your child receives special education services but is also mainstreamed in regular education classes, please list classes for which the child is mainstreamed. _____

_____

The Miller Speech and Hearing Clinic shall not discriminate on the basis of race, national origin, religion, age, sex, sexual orientation, or handicapping condition.

Person completing form _____

Relationship to Child_____

Signature **_____*Date*_____**

I agree to permit Texas Christian University students, enrolled in pertinent academic training programs, to participate and observe in the evaluation and/or treatment procedures which will be conducted under the supervision of the faculty of the clinical programs. In addition, I agree to permit the use of closed-circuit television, the taking of photographs or video recordings, audio recordings, or similar graphic material which is to be used for teaching or scientific purposes.

Signature **_____*Date*** **_____**

I understand that the Miller Speech and Hearing Clinic does not file insurance for clinical services. Upon request, the clinic will supply me with an itemized statement that may be attached to my insurance form and submitted to my insurance company. I understand that all charges incurred are my responsibility and that insurance agreements are between the agency and the client, NOT the agency and Miller Speech and Hearing Clinic.

Signature **_____** ***Date*** **_____**