Child Case History

Date of Visit _____

Child's Name _____ D.O.B _____

Parent's Name _____

HOW DID YOU HEAR ABOUT US?_____

GENERAL INFORMATION

What is your primary concern? _____
When did you first notice the problem?_____
Has your child's hearing ever been tested before? Yes_____ No_____
If Yes, what were the results? _____
Current Physician _____ Phone number _____

HEALTH HISTORY

Has your child had bacterial meningitis, or other infections? Yes_____ No_____
If yes, please explain_____
Has your child ever had repeated ear infections? Yes_____ No_____
Has your child ever had pressure equalization tubes? _____
Has your child ever taken medication regularly? Yes_____ No_____
If yes, please describe _____
Does your child have any allergies? Yes_____No_____
If yes, please describe _____

Does anyone in your family have a hearing loss or speech problem? Yes_____ No_____
If so, what is their relation to your child? _____
Your child's general health is Excellent_____Good_____Fair_____Poor_____

DEVELOPMENTAL HISTORY

Primary language spoken at home _____
Please check all that apply; Does your child respond appropriately to:

_____ His name when called
_____ Favorite TV programs or movies
_____ Startle to sound while resting
_____ Questions
_____ Commands or requests
_____ The direction sounds come from

Please check all that apply: My child has been diagnosed with:

_____ Attention Deficit Disorder
_____ Developmental Delay
_____ Down's Syndrome
_____ Autism
_____ Vision Problems
_____ Muscular Dystrophy
_____ Speech/Language Delay
_____ Learning Disability
_____ Cerebral Palsy
_____ Other (Please Explain)

EDUCATION/AMPLIFICATION HISTORY

School name and address _____
Grade _____ Teacher's name _____
Has your child ever repeated a grade? Yes_____ No_____
Has your child ever been placed in special education? Yes_____ No_____
If yes, please explain _____
Has your child ever received hearing/speech/language services? Yes_____ No_____
Has your child ever had a hearing aid? Yes_____ No_____