



## 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: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Preferred Pronouns: \_\_\_\_\_

Race/Ethnicity (Check all that apply):  Prefer not to answer  American Indian/Alaskan Native  Asian  Black/African American  Latino/Hispanic  Native Hawaiian/Other Pacific Islander  White

Address: \_\_\_\_\_  
(# Street)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Parent #1: \_\_\_\_\_ Preferred pronouns: \_\_\_\_\_ Relationship to the child: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_  Cell Phone: \_\_\_\_\_  Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
*check preferred number to contact*

Occupation: \_\_\_\_\_ Legal guardian: Yes  No  Does child live with this parent: Yes  No

Parent #2: \_\_\_\_\_ Preferred pronouns: \_\_\_\_\_ Relationship to the child: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_  Cell Phone: \_\_\_\_\_  Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
*check preferred number to contact*

Occupation: \_\_\_\_\_ Legal guardian: Yes  No  Does child live with this parent: Yes  No

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: \_\_\_\_\_

For what reason: \_\_\_\_\_

#### 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"/>	Head Injury	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Adenoidectomy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hospitalization	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Attention Deficit Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Meningitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Autism Spectrum Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mental Illness	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"/>	Scarlet Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Concussion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinusitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Down Syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Swallowing Difficulty	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ear Infections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid Problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emotional Difficulties	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tonsillectomy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Encephalitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tonsillitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fainting Spells	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Vision Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Feeding Difficulty	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Voice Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fetal Alcohol Syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Whooping Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent Colds	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Headaches	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): \_\_\_\_\_

\_\_\_\_\_

Has your child ever taken any of the following medications:

- Aminoglycoside antibiotics, such as gentamicin, streptomycin, and neomycin
- Water pills or diuretics
- Quinine-based medications for malaria or muscle cramps
- Chemotherapy drugs, including cisplatin

Primary Care Physician'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 to one or both of the previous two questions, 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

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? \_\_\_\_\_

\_\_\_\_\_

Are there any other family members with hearing loss? Yes  No

If so, list relationship and explain type of 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? \_\_\_\_\_

At what age did the child use 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 or hear 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

Agency/Speech-language pathologist's name \_\_\_\_\_

(Please provide a copy of any previous evaluation reports)

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

Agency/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.

<b>Service</b>	<b>In School</b>	<b>Out of School</b>	<b>Agency</b>
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

RTI? 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 and Audio/Video Recording
- Authorization to Obtain, Release and Discuss Client Information

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

- |   |  |
|---|--|
| <input type="checkbox"/> Speech-language evaluation         | <input type="checkbox"/> Neuropsychological evaluation |
| <input type="checkbox"/> Hearing evaluation                 | <input type="checkbox"/> Report Card                   |
| <input type="checkbox"/> Individualized Educational Program | <input type="checkbox"/> Progress Reports              |
| <input type="checkbox"/> 504 Accommodation Plan             | <input type="checkbox"/> Other relevant documentation  |

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

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FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

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\_\_\_\_\_ 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: \_\_\_\_\_  
\_\_\_\_\_

**Please answer questions 13 and 14 only if your child has had previous treatment.**

13. What have you found most helpful in your previous therapy experiences? \_\_\_\_\_  
\_\_\_\_\_

14. What have you found least helpful in your previous therapy experiences? \_\_\_\_\_  
\_\_\_\_\_

15. What do you hope will happen as a result of therapy? \_\_\_\_\_  
\_\_\_\_\_

16. 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  
(person completing form)

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



Authorization to Obtain, Release, and Discuss Client Information

Client's name \_\_\_\_\_  
                                Print first name                                  middle initial                                  last name

Client's date of birth \_\_\_\_\_

Check all that you authorize:

- Get information from
- Send information to
- Discuss information with

\_\_\_\_\_

Print first and last name of person

\_\_\_\_\_

Print name of facility

\_\_\_\_\_

Print street address

\_\_\_\_\_

Print City, State, and Zip Code

\_\_\_\_\_

Phone number

\_\_\_\_\_

Fax number

Please check

- I agree to have a graduate student clinician under the supervision of a clinical instructor, and / or the clinical instructor, obtain/release/discuss (see above) the following information from/to/with the above listed person/facility.
- I agree to have the audiologist obtain/release/discuss (see above) the following information from/to/with the above listed person/facility.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorization: \_\_\_\_\_  
                                Signature of client or guardian                                  relationship to client

Date: \_\_\_\_\_

Clinical instructor reviewed: \_\_\_\_\_