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)

SPEECH–LANGUAGE–HEARING CENTER

Child Case History Form (Confidential)

Please complete this form and send it and additional relevant reports (speech-language, hearing, neurology, psychology) from other agencies to the address above. This information will help us to plan your evaluation and/or treatment.

Personal Information

Date:_____

Child's Name:_____ Date of Birth:_____ Age:____ Gender:_____

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:_____ 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:_____ 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 ☐	No ☐	Head Injury	Yes ☐	No ☐
Adenoidectomy	Yes ☐	No ☐	Heart Problem	Yes ☐	No ☐
Allergies	Yes ☐	No ☐	High Fever	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐	Hospitalization	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Measles	Yes ☐	No ☐
Attention Deficit Disorder	Yes ☐	No ☐	Meningitis	Yes ☐	No ☐
Autism Spectrum Disorder	Yes ☐	No ☐	Mental Illness	Yes ☐	No ☐
Behavioral Difficulties	Yes ☐	No ☐	Mumps	Yes ☐	No ☐
Bipolar Disorder	Yes ☐	No ☐	Neurological	Yes ☐	No ☐
Cancer/Tumor	Yes ☐	No ☐	Noise Exposure	Yes ☐	No ☐
Cerebral Palsy	Yes ☐	No ☐	Paralysis	Yes ☐	No ☐
Chicken Pox	Yes ☐	No ☐	Pneumonia	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 ☐
Headaches	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):_____

_____

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

Pregnant person'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 the 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 the 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 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 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 they have speech-language difficulty? Yes ☐ No ☐

If yes, please explain:_____

_____

Describe what happens when the child has trouble communicating?_____

_____

_____

Educational/Social History

Current school:

Preschool ☐ Elementary ☐ Middle School ☐

High School ☐ Home Schooled ☐ Grade: _____

Name of current school: _____

Did the child repeat or skip a grade? Yes ☐ No ☐

If yes, please explain:_____

_____

Describe your child's attendance at school:_____

_____

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 more challenging 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	Agency
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 ☐ I do not know ☐

a 504 plan? Yes ☐ No ☐ I do not know ☐

MTSS/RTI? Yes ☐ No ☐ I do not know ☐

other? Yes ☐ No ☐ I do not know ☐

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 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?

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 the Center at 508-929-8055

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

_____ Diagnostic Evaluation
_____ Therapy

Date Received: _____
(Office Use Only)

WORCESTER STATE UNIVERSITY

Name: _____

SPEECH–LANGUAGE–HEARING CENTER
486 Chandler Street
Worcester, Massachusetts 01602
508-929-8055 • Fax: 508-929-8175

DOB: _____

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

Please complete this form and send it and additional relevant reports (speech-language, hearing, neurology, psychology) from other agencies to the address above. This information will help us to plan your evaluation and/or treatment.

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 their stuttering? _____
   _____

6. Do you think the child is aware of their 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 they are 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. _____

_____

WORCESTER STATE UNIVERSITY

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

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: _____

WORCESTER STATE UNIVERSITY

Speech-Language-Hearing Center
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
(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

Revised/Fall 2016

WORCESTER STATE UNIVERSITY

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Fax: 508-929-8175

Consent for Access to Records

I consent and authorize the Worcester State University (WSU) Speech-Language-Hearing Center (SLHC) to allow faculty and clinical instructors connected with the WSU Department of Communication Sciences and Disorders to access and use my records/_____'s records (without the use of identifying
Client name
information) for research and/or academic purposes at WSU.

_____ _____
Signature Date

_____
Print name

WORCESTER STATE UNIVERSITY

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Client Consent for Research

Client Name: _____

The Speech-Language-Hearing Center serves as a training site for students in the Communication Sciences and Disorders Department at Worcester State University. As a research and teaching institution, we are asking your permission to use de-identified (your personal information has been removed) information for teaching and research purposes. An example of a teaching activity might be using de-identified test information to instruct students on how to administer a test and interpret scores. An example of a research activity might be, with permission from our Institutional Review Board, using de-identified information in presentations or in research papers.

I consent to allow members of the Communication Sciences and Disorders Department at Worcester State University to use de-identified information for:

- teaching purposes:
  - ☐ YES
  - ☐ NO
- research purposes:
  - ☐ YES
  - ☐ NO

I consent to be contacted regarding participation in a research study:

- ☐ YES
- ☐ NO

_____

Client or Parent/Legal Guardian

_____

Date