

File Number: \_\_\_\_\_

**Andrews University**  
**Department of Speech-Language Pathology and Audiology**  
**Child Case History Form**

**\*\*PLEASE PRINT CLEARLY WHEN FILLING OUT THIS FORM – THANK YOU\*\***

Child's Name: \_\_\_\_\_ Sex: M / F  
(Please Circle)

Parent or Guardian: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Parent(s) Occupation(s) \_\_\_\_\_  
\_\_\_\_\_

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

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

Home Phone Number: \_\_\_\_\_ (Y / N) Daytime: \_\_\_\_\_

(Please indicate if a voice mail message is acceptable when leaving patient information: i.e. appt. time, results, messages)

Birth date: \_\_\_\_\_ School: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Test: \_\_\_\_\_ Referral Source: \_\_\_\_\_

(i.e. self, doctor, teacher, ect.)

Has your child had a complete hearing evaluation before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Where? \_\_\_\_\_ When? \_\_\_\_\_

What were the results? \_\_\_\_\_

Student Clinician(s): \_\_\_\_\_  
\_\_\_\_\_

Child Case History Form

FILE NUMBER \_\_\_\_\_ Patient Initials \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ Hearing Loss (right, left, both) \_\_\_\_\_ Tinnitus/Ringing \_\_\_ Dizziness  
\_\_\_\_\_ Listening in background noise \_\_\_\_\_ No hearing problems noticed  
\_\_\_\_\_ Central Auditory Processing Evaluation

If you child has a hearing problem, how long have you noticed this difficulty? \_\_\_\_\_

Has your child's hearing ability changed recently? \_\_\_\_\_ Yes \_\_\_\_\_ No (sudden or gradual)  
(circle one)

Has your child even been exposed to loud sounds, either recently or in the past? Yes / No  
(circle one)

If yes please mark all that apply: \_\_\_\_\_ Farm machinery \_\_\_\_\_ Power Tools \_\_\_\_\_ Military  
\_\_\_\_\_ Hunting/shooting \_\_\_\_\_ Factory Noise (with or without ear protection) \_\_\_\_\_ Airplanes  
\_\_\_\_\_ Music \_\_\_\_\_ Car stereo \_\_\_\_\_ I-Pod \_\_\_\_\_ Concerts \_\_\_\_\_ Recreational Vehicles  
(ATV, etc.)

Has your child seen an Ear, Nose and Throat Physician? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, why did he/she see the physician? \_\_\_\_\_  
Has he/she had ear surgery before? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, when did he/she have the surgery and for what problem? \_\_\_\_\_

Do you know of other family members who have hearing loss? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, who? \_\_\_\_\_

Has your child ever been diagnosed with a medical condition (i.e. A.D.D., etc.)? Yes / No  
(circle one)  
If yes, what? \_\_\_\_\_

List all medications that your child has taken within the last 3 moths or takes now on a regular basis.  
Explain what the medication is for and how long he/she has taken it. Include non-prescription  
(holistic, natural, etc.) medications as well.

Medication: \_\_\_\_\_ How long? \_\_\_\_\_ For: \_\_\_\_\_  
Medication: \_\_\_\_\_ How long? \_\_\_\_\_ For: \_\_\_\_\_  
Medication: \_\_\_\_\_ How long? \_\_\_\_\_ For: \_\_\_\_\_

Current Grade in School \_\_\_\_\_

What are your child's favorite subjects in school? \_\_\_\_\_

What are your child's least favorite subjects? \_\_\_\_\_

How does he/she feel about school/teachers? \_\_\_\_\_

Does your child currently qualify for Special Education services? Yes / No

If yes, please list and explain: \_\_\_\_\_

Please place a check mark by any of the following items that apply to your child.

- \_\_\_\_\_ Says "what" or "huh" often
- \_\_\_\_\_ Complains that people sound like they are mumbling
- \_\_\_\_\_ Listening to directions at school is difficult
- \_\_\_\_\_ Difficulty with reading
- \_\_\_\_\_ Difficulty with spelling
- \_\_\_\_\_ Difficulty with writing
- \_\_\_\_\_ Has difficulty following 3 step directions at home
- \_\_\_\_\_ Seems to have more difficulty listening when there are distractions (background noise)
- \_\_\_\_\_ Seems to give slow or delayed response to verbal stimuli – questions
- \_\_\_\_\_ Works well one-on-one but not in a group setting
- \_\_\_\_\_ Confuses words that sound alike
- \_\_\_\_\_ Frequently misunderstands what people say
- \_\_\_\_\_ Expresses thoughts that he/she feels stupid, or dumb
- \_\_\_\_\_ Seems easily distracted
- \_\_\_\_\_ Seems very tired at the end of the school day
- \_\_\_\_\_ Says "I heard you but I didn't understand you" often
- \_\_\_\_\_ Very good at mechanical tasks
- \_\_\_\_\_ Very good at visual tasks

Has he/she ever had any IQ/Psychological tests? Yes / No When? \_\_\_\_\_

Where? \_\_\_\_\_ By Whom? \_\_\_\_\_

Results: \_\_\_\_\_

Has he/she ever had speech and language tests? Yes / No When? \_\_\_\_\_

Where? \_\_\_\_\_ By Whom? \_\_\_\_\_

Is your child currently in speech therapy? Yes / No If yes, for how long? \_\_\_\_\_

Please describe your main concern about your child's hearing ability or processing ability:

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