WELCH-SCHMIDT CENTER FOR COMMUNICATION DISORDERS
MARTIN 34
WARRENSBURG, MISSOURI 64093
660-543-4993

CHILD CASE HISTORY - HEARING

Before an assessment is scheduled we would appreciate you answering the following questions as accurately and completely as possible. When the form is completed, please mail it in the enclosed postage paid return envelope. You will be contacted for an assessment appointment when we receive the completed case history form. All information is for the confidential use of our clinic staff.

Date: _____

Name:_____ Date of Birth: _____/_____/_____
(Last) (First) (MI) MM DD YYYY

Address: _____ Age: _____ SEX: [ ] M [ ] F

_____ Grade in school: _____

Person completing form: _____ relationship to child_____

Parents names:_____

Phone: _____-_____-_____ home Phone: _____-_____-_____ Wk / Cell

e-mail address: _____

Who referred the child and why? _____

Do you think the child has a hearing loss? Yes [ ] NO [ ]
If yes, describe problem. If no, indicate why child is being tested. _____

_____

MEDICAL HISTORY:

Length of pregnancy _____ Birth weight _____lbs _____oz

List any complications/problems during pregnancy: _____

_____

List any complications/problems during or soon after birth:_____

_____

Ear infections? [ ] Yes [ ] No How often? _____ Age of 1st infection _____

Pressure Equalization Tubes? [ ] currently [ ] previously when? _____

Has the child ever had any ear surgery? [ ] Yes [ ] No. If yes, explain _____

_____

High fevers (specify) _____

Colds/Allergies (specify) _____

Is the child currently taking any medication? [ ] Yes [ ] No If yes, what_____

Has the child ever seen a professional (doctor, audiologist, etc.) regarding hearing health? _____

If so, when, who and were there recommendations? _____

_____

Has the child ever had any severe head injury? [ ] Yes [ ] No Date: _____

Other physical/medical problems _____

_____

_____

BEHAVIORAL HISTORY:

Does child respond to loud noises? [ ] Yes [ ] No

Age of 1st words _____ Does child use sentences? [ ] Yes [ ] No

Does child have a speech problem? [ ] Yes [ ] No Describe _____

_____

FAMILY HISTORY:

Does anyone in the child's family have a hearing loss? [ ] Yes [ ] No

If yes, relationship _____

ENVIRONMENTAL HISTORY:

Has child been exposed to excessively loud noise for prolonged periods of time (farm machinery, gunfire, music, etc.) ? [ ] Yes [ ] No

If yes, describe _____

HEARING AIDS:

Has the child ever worn hearing aids? [ ] Yes [ ] No

If yes, [ ] Right [ ] Left Make: _____ Model: _____

How long have they been worn? _____

Do they seem to help? [ ] Yes [ ] No

Please add any information which you feel might be useful/helpful _____

_____

_____