



Case History

Name: _____ Date: _____

Concern/Reason for Visit: _____

Who referred you to our clinic? _____

School/Employer: _____

Primary Care Physician/Pediatrician: _____

AUDIOLOGY *Please check all that apply:*

Ear infection/s (how many) _____	Meningitis	Chemotherapy
Tubes	Allergies	In utero infection (CMV, Rubella)
Medication/Drugs during Pregnancy		Problems during pregnancy/childbirth
Ventilation of ECMO use	Pain/Pulling ear	Ear/head trauma
Dizziness (describe): _____	Neurodegenerative Disorder	
Ringing in ears	Red ears	Fluctuating hearing loss
Exposure to loud noise	Drainage	Sudden hearing loss
Other _____		

Hospitalizations? Surgeries? _____

Current medical condition: Poor Fair Good Excellent

List medications: _____

Do you wear Hearing Aids? Yes No

Is there a family history of hearing loss? Yes No

Passed newborn hearing screening? Yes No

SPEECH

Please give **age of development** (year and month) for these **speech and motor** milestones:

Making speech sounds (babbling) _____ First words _____

Using 2-3 word phrases _____ Walked at (age) _____

How many words are in the child's vocabulary? _____ Balance normal? Yes No

Have ear infections been frequent? Yes No Are P.E. tubes present? Yes No

Has child ever been evaluated for speech/language delay? Yes No

Is the child currently receiving speech therapy? Yes No

Has the child received speech therapy in the past? Yes No

Where? _____

Does child respond when his/her name is called? Yes No

Does the child understand most of what you say? Yes No

Does child give good eye contact? Yes No Does child point? Yes No

Does child look when you point? Yes No

Does child imitate words you say? Yes No

Does child have siblings? Yes No Ages? _____

Is there a family history of speech/language delay? Yes No

Does the family have any spiritual, cultural, or religious beliefs that influence the child: Yes No

OCCUPATIONAL THERAPY

Please check all that apply:

Please give **age of development** (year and month) for these **motor** milestones:

Sat upright _____ Crawled _____ Walked at (age) _____

Fed self _____ Fork/Spoon _____ Drink open cup _____

Dresses self _____ Toilet trained _____

Balance normal? ___ Yes ___ No

Has child ever been evaluated for fine motor, oral motor, self-help or sensory motor delay?

___ Yes ___ No

Is the child currently receiving occupational therapy? ___ Yes ___ No

Has the child received occupational therapy in the past? ___ Yes ___ No

Where? _____

Any other comments? Please write below.