THE UNIVERSITY of NORTH CAROLINA
GREENSBORO
School of Health and Human Sciences

UNCG Speech and Hearing Center
Department of Communication Sciences & Disorders

CHILD AUDIOLOGY CASE HISTORY

All information provided on this form will be held in the strictest confidence in accordance with HIPAA regulations.

Name: _____ Gender: _____ Birthdate: _____

Address: _____

Parent/Guardian's Name: _____ Phone: _____

Person completing this form: _____ Relationship to child: _____

Language(s) spoken in the home: _____

Referral Source: _____

DESCRIPTION OF THE PROBLEM

What are your concerns regarding your child's hearing and/or listening? _____

_____

_____

What question(s) would you like answered? _____

_____

_____

AUDIOLOGICAL HISTORY

	YES	NO
Does your child seem to have difficulty hearing?		
Does your child localize to sound?		
Does your child report ringing or other sounds in his/her ears or head?		
Does your child complain about fullness or pressure in one or both ears		
Has your child had problems with dizziness or balance?		
Does your child seem to have any difficulty understanding speech or directions?		
Are there certain environments in which your child has more difficulty listening?		
Does your child have problems remembering information s/he has heard (e.g., oral directions)?		

Describe listening difficulties: _____

_____

_____

BIRTH/DEVELOPMENTAL HISTORY

Length of Pregnancy (weeks): _____ Birth Weight: _____ APGAR Scores (if known): _____

Describe any abnormalities associated with the pregnancy or birth of this child: _____
_____
_____

Was child in the Neonatal Intensive Care Unit (NICU)? ___Yes ___No. If so, how long? _____

Describe any unusual events or problems following birth. _____
_____
_____

Was your child delayed in meeting developmental milestones (e.g., crawling, walking, speaking)? ___Yes ___No
Describe: _____
_____

Compared to other children the same age, how well does your child keep his/her balance, run, and use his/her hands?_____
_____

HEALTH HISTORY

Describe your child's current health status: _____
_____
_____

Current weight _____ Current height _____ Handedness: ___Right ___Left ___Either

Check all that apply:

___ Cleft Lip and/or Palate
___ Fetal Alcohol Syndrome
___ Down Syndrome
___ Developmental Delays
___ Asperger Syndrome
___ Attention Deficit Disorder
___ Tourette's Syndrome
___ Language Learning Disability
___ Pervasive Developmental Disorder
___ Auditory Processing Disorder
___ Seizure Disorder
___ Hearing Loss
___ Autism
___ Other: _____

Check any illnesses that your child has had. Please add any others not listed.

___ Measles
___ German Measles
___ Laryngitis
___ Meningitis
___ Encephalitis
___High Fevers
___ Asthma
___ Diabetes
___ Chicken Pox
___ Mumps
___ Allergies
___ Cancer
___Hand, Foot, and Mouth disease
___ Pertussis (Whooping cough)
___ Frequent cases of flu
___ Other: _____

Does your child a history of ear infections? ___Yes ___No Estimate the number of occurrences, age of child, and specify method of treatment: _____
_____

Do you believe your child's communication difficulty arises from an injury or illness? ___Yes ___No
Describe:_____
_____

Did your child ever require hospitalization? ___Yes ___No. Indicate reason, child's age at admission, and length of stay:
_____
_____

Medication(s) your child currently is taking on a regular basis (specify the reason for each): _____
_____

FAMILY HISTORY

Please complete the following for all members of the immediate family:

Name	Age	Gender	Grade/Occupation	Hearing, Speech-Language, Attention, or Learning Problems
1.				
2.				
3.				
4.				
5.				

ACADEMIC HISTORY

School child attends: _____ Grade: _____

Specify: ___ Private ___Public ___Homeschool __Other _____

Describe your child's school performance: _____
_____
_____

Strongest subjects: _____ Weakest subjects: _____

Has your child's teacher expressed concerns about his or her speech, language, or academic skills? ___Yes ___No
Describe: _____
_____

Does your child have a current IEP (Individualized Educational Program) or 504 Plan? ___Yes ___No
In what area(s) does s/he qualify for services? _____
_____

Is your child receiving services or accommodations at school? ___Yes __No Describe: _____
_____

How does your child get along with others at school? _____
_____

Are you concerned about behavioral issues at school or home? ___Yes ___No Describe: _____
_____

EVALUATIONS AND TREATMENT
Please provide copies of reports for all prior evaluations.

Has your child had a prior speech-language evaluation? ___Yes ___No When? _____
Examiner? _____ Results: _____
_____

Does your child currently receive speech-language therapy or tutoring? ___Yes ___No
With whom? _____ Describe the nature of the therapy/tutoring: _____
_____

Did your child receive speech-language therapy or tutoring in the past? ___Yes ___No Provide dates of service and specify reason for discontinuation: _____
_____

Has your child had a hearing test or auditory processing evaluation? ___Yes ___No When? _____
Examiner? _____ Results: _____
_____

Has your child had a neurological evaluation? ___Yes ___No When? _____
Examiner? _____ Results: _____
_____

Has your child had a psycho-educational evaluation? ___Yes ___No When? _____
Examiner? _____ Results: _____
_____

ADDITIONAL INFORMATION

Please attach any additional information you think will help us in addressing your concerns. **Thank you!**