Baylor University
ROBBINS COLLEGE OF HEALTH AND HUMAN SCIENCES
Communication Sciences and Disorders

Baylor Speech-Language & Hearing Clinic
Speech-Language Case History
Pediatric – Re-evaluation

Alert:

Date: _____

Identifying Information

Child's Name: _____
Age:_____DOB:_____Sex: Male Female Current grade in school: _____
Home Street Address: _____
City:_____State:_____Zip code: _____
Mother's Name:_____Age:_____
Address: _____
Home phone:_____Work phone:_____Cell phone: _____
Occupation:_____Email: _____
Father's Name:_____Age:_____
Address: _____
Home phone:_____Work phone:_____Cell phone: _____
Occupation:_____Email: _____
Guardian Name:_____Age:_____
Address: _____
Home phone:_____Work phone:_____Cell phone: _____
Occupation:_____Email: _____

Home Language_____Other languages spoken in the home _____
Have you been seen at this facility previously?_____Date/s: _____

Does your child have hearing problems? Y N If yes, what is being done? _____

Does your child have vision difficulties? Y N If yes, what is being done?

Statement of CURRENT Problem/ Referral:

Describe as completely as possible the CURRENT speech, language, and hearing problem today since the original evaluation.

_____
_____
_____
_____
How has the problem changed since you first noticed it? _____
_____
What has been done about it? Has this helped? _____
_____

Is your child aware of the problem? Explain

_____

Tell your child's reaction to his own speech difficulties _____

Tell the reaction of you and other family members to the problem_____

Please tell us more about recent evaluations or services provided with approximate dates:

Speech therapy: _____		Physical therapy: _____	
Occupational therapy: _____		Cook's Children's Hospital, Dallas	
Scottish Rite Hospital, Dallas		Callier Center, Dallas	
Klaras Center, Waco		MHMR, Waco/other	
Child Protective Services		Counseling services	
Psychological services		Public school	
Audiology		Other	

Family

Others living in the home:

Name	Age	Relationship	Diagnosed Speech/Learning Problem

Prenatal, Birth History, and Child Development were provided on original form. Yes No

Emotional and Behavioral changes since initial evaluation.

Check if they apply:

Behavior	**Home**	**School**	**Other**
Compliant behavior			
Learning problems			
High activity level for age			
Difficulty following directions			
Difficulty maintaining attention			
Impulsivity (not thinking before acting)			
Difficulty playing with others			
Prefers to play by him/herself			
Difficulty getting along with peers			
Problems with adult authority			
Aggressive			
Behavior problems			
Friendly, outgoing			
Shy			
Easily distracted by:			

Toys or activities the child prefers to play with: _____

_____

Describe any discipline difficulties: _____

How do you discipline at home? _____

Explain current significant family stresses _____

Previous family stressors _____

Speech and Language Development changes since the initial evaluation.

_____

_____

Speech and Language Treatment History

_____

_____

Medical History - additions since initial evaluation

List any food allergies:

_____

_____

_____

Illnesses/Conditions

Check those that apply and fill in approximate date/s:

Allergies		Hearing aids- which ear R L	
Amputations		Hearing amplification device	
Asthma		Hearing problems	
Attention Deficit Disorder		High fevers	
Augmentative communication device		Hoarseness	
Autism		Lengthy medication treatment	
Auto accidents		Measles	
Behavior problems		MR	
Braces		Nightmares	
Brain injury		Obturator	
Cerebral palsy		Other surgery:	
Chickenpox		Hospitalization for _____	
Cleft palate/submucous cleft		Pervasive Developmental Disorder	
Cochlear implant		Physical Abnormalities	
Convulsions		Poor appetite	
Digestive problems		Schizophrenia	
Down's Syndrome		School phobia	
Drooling		Seizures	
Dyslexia		Serious injury:	
Ear infections		Hospitalization for _____	
Emotional problems		Stuttering	
Encephalitis		Swallowing problems	
Falls frequently/balance		Syndrome (other): _____	
Feeding/eating problems		Thumbsucking	
Fragile X Chromosome Disorder		Tongue-tie	
Frequent colds		Tonsillectomy and/or Adenoidectomy	
Glasses		Tubes in ears	
Hand preference R L		Vision problems	
Head injury		Vocal nodules	

Is the child currently under a doctor's care? _____

_____

What current medication is he/she taking?

_____

School History - since initial evaluation

_____

_____

Schools attended:

School/ Dates	Grade Level	Name of School	Academic Strengths	Academic Weaknesses
Day care/Nursery				
Preschool				
PPCD				
Kindergarten				
Elementary				
Middle School				
High School				

Has your child been held back or repeated a grade? Y N Explain _____

_____

Currently, what are your child's grades? _____

Has your child been tested at school to address developmental, learning or speech-lang. difficulties?

Y N If yes, explain Results: _____

_____

What special education services has your child received for difficulties in school? (check all that apply)

Speech therapy ____ resource ____ self-contained _____ OT _____ Other: _____

What modifications have been used in school to support your child? _____

_____

How does he/she feel about school? _____

Does your child learn easier for a particular style of learning? Explain:

Auditory_____

Visual_____

Both _____

Other activities your child is involved in outside of school (sports, lessons, church, tutoring, Scouts, etc.):

_____

_____

Please give any additional information that will help us in evaluating your child: _____

_____

Child's primary physician

Name_____

Address_____

Phone Number_____

Diagnosis _____

Other professionals who have treated/evaluated the child

Name/Position_____

Address_____

Phone Number_____

Diagnosis _____

I wish reports to be sent to these persons/agencies:

Name_____

Title_____

Address_____

Phone _____

Name_____

Title_____

Address_____

Phone _____

_____ _____ _____

Signature of person completing this form Relationship to child Date