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

Baylor Speech-Language & Hearing Clinic
Speech-Language Case History
Pediatric

Date: _______________

Alert:

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: _________________________

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? _________________________
____

I. Statement of Problem/ Referral: MUST ANSWER THESE QUESTIONS
Describe as completely as possible the speech, language, and hearing problem. _____________________
____
____
Referral Source: ____
When was the problem first noticed? ____
____
How has the problem changed since you first noticed it? ____
____
What has been done about it? Has this helped? ____
____
What do you think caused the problem? ____
____

What do you hope to learn from this evaluation and what do you think should be done?
____
____
Can you understand your child's speech? ____
Name others who have difficulty understanding speech ______________________________________
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_________________________________
____
Family history of speech/language problems ____
____
What do you do to help your child? ____
If your child has difficulty producing sounds, which ones are problems? __________________________
Does your child understand words spoken to him/her? ______________________________________
Does he/she understand conversation? ____
Does your child repeat words or show difficulty with breaks in his speech? _________________________
____
Does your child stutter: none _____ rarely _____ occasionally _____ frequently _____
If yes, then how long has this been a problem? ____
Does your child have an unusual voice quality? (loud, soft, hoarse, nasal) ___________________________
Give other information to explain your child's communication problem ____________________________
____

Does your child use augmentative communication system? If so, explain:
____
____

Tell us more about previous 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	

List diagnosis/es: ____
Describe services: ____
____
____

Family

Others living in the home:

Name	Age	Relationship	Diagnosed Speech/Learning Problem

Is the child adopted? ________________________ Age adopted __________________

This information is important for diagnosis and treatment. Please answer carefully and specifically.

<u>Histories</u>

Prenatal and Birth History : Check if they apply

A. Pregnancy

Full term ____ Pre-Term ____ Number of weeks gestational _____ Normal Birth _____

If problems existed, please check those that apply:

Excessive bleeding		German measles		Mother – bed rest	
High blood pressure		Diabetes		Smoking	
Previous miscarriage		RH incompatibility		Brain injury	
Toxemia		X-ray treatment		Serious accident	
Premature membrane/ Rupture		Mother- alcohol use / abuse		Mother – drug use / abuse	

Comments: ____

____

B. Birth

Full term ________ Normal Birth _____

Length of labor _______ Birth weight ______ Birth length _____

If problems existed, please check those that apply:

Vaginal birth		C-Section		Breech	
Breathing problems		Jaundice		Extended hospital stay	
Incubator		Cyanosis		Seizures	
Injury		Deformity		Infection	
Anoxia		Difficult delivery		Feeding difficulty	
Cleft/ lip palate		Swallowing/sucking problems		Physical Abnormalities Specify _____________	

Explain any complication related to birth ____

____

III. Child Development

Your general impression of the child's overall development:

slow _____ normal_____ advanced_____

A. Motor development

slow _____ normal ____ advanced ____

Give age:

Age sat alone		Age crawled		Age reach and grasp	
Age walked		Age potty trained		Age feed self	
Age dressed self					

Explain/note any motor difficulties: ____

____

B. Emotional and Behavioral

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:			
Overly sensitive to stimuli			
Low response to stimuli			

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 ____

C. Speech and Language Development

Fill in age that behaviors began:

Cooing sounds		Vocal play/babbling	
First words		Phrases	
Short sentences			

Tell the way your child lets you know what he/she wants **at this time**

Eye gaze		Pointing	
Gestures		Moves other's hand/body	
Single words		2-3 word phrases	
Crying		Vocalizing	
Complex sentences		Signs / augmentative	

IV. Medical History

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		Sensori-integration disorder	
Ear infections		Serious injury:	
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	

Allergies:
List all food allergies:
____
____
____
Is your child allergic to latex? **Yes** **No** **Not Known**

Is the child currently under a doctor's care? Give diagnosis and physician's names:
____
____
____
What current medication is he/she taking? _______________________________________
____
Hospitalizations: date(s) /cause(s) ____
____
Is he/she on a special diet or diabetic diet? ______________________________________

Is your child a pickyeater?____
Explain:
____
____

Does your child have any chewing or swallowing difficulties? ____________________
Describe any major illnesses/accidents: ____
____

V. School History
Schools attended:

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

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

Reviewed January 11, 2007

Baylor University Speech-Language & Hearing Clinic

AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I, ________________________________ who resides at ______________________________

In the city of ___________________ in the state of __________________ hereby authorize:

Baylor University Speech-Language & Hearing Clinic
PO Box 97332
Waco, Texas 76798-7332

to disclose the following specific health information by □ mail or □ fax or □ email to:

Name: ____

Address: ____

City, St., Zip: ____

from the Health Records of:

Name: ____

(NAME OF INDIVIDUAL WHOSE RECORD IS BEING DISCLOSED)

Address: ____

City, St., Zip: ____

For the purpose of: ____

My authorization extends only to those data elements/documents initialed below:

______________ Diagnostic Reports

______________ Hearing Reports

______________ Session Reports

______________ Test Results

______________ All of the above

______________ Other (must be specific) ____

____

AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS
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This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, expect as otherwise provided by law.

2. A photocopy or fax of this authorization is as valid as this original.

3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if noted below.

4. Baylor University, its employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.

6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

____
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

____
DATE

____
PATIENT'S NAME PRINTED

____
EXPIRATION DATE (IF OTHER THAN ONE YEAR FROM ABOVE DATE)

____
WITNESS

____
DATE

Baylor University Speech-Language & Hearing Clinic

P.O. Box 97332
Waco, TX 76798-7332

Release of Information

Date: _______________

RE: Name: ____ DOB: __________________

To Whom It May Concern:

I hereby grant permission for ____ to disclose and deliver
(name of school/institution or above agencies)

any information requested by ____ concerning my
(name of school/institution)

son/daughter ____.

This information may include case history, results of examination, impressions, and recommendations

that might benefit ____ in treating
(name of school/institution)

__________________________________ speech and communication disorder.

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
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____
Signature

____
Relationship

Consent Agreement

I understand that the Baylor University Speech and Hearing Clinic, hereafter referred to as the Center, is operated as a training center for speech-language pathologists and that all therapy conducted at the Center is supervised by a licensed clinician and that all lessons may be observed by students in training or by students who may be interested in majoring in this field.

I further understand that many of the lessons are recorded by television or on tape recorder and that these lessons may be played in speech therapy classes as examples of speech, language, and hearing disorders or may be presented at professional meetings of doctors, dentists, psychologists or speech clinicians or other professional groups and that these recordings may be analyzed and the information used for research reports. I also understand that testing information and treatment progress as recorded in the client file may be used for research purposes. I further understand that when such usages are made of this information or recordings, that the names of the patients treated will be concealed.

I agree and understand that Baylor may freely use these tapes and files for purposes of education and research.

I further agree and understand that by signing this Consent Agreement, these recordings and files become the property of the Center and I hereby relinquish any and all claims to benefits, financial or otherwise which I had, now have, or may have in the future or which my heirs, executors, administrators, or assigns may have or claim to have from the use of these recordings.

BY: ____

(Date)