

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

**Pediatric – Re-evaluation**

Alert:

Date:

## Identifying Information

**Child’s Name**:

Age: DOB: Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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?

This information is strictly confidential and cannot be provided to individuals or agencies without written consent

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 Spectrum |  | Intellectual Disability |  |
| Auto accidents |  | Lengthy medication treatment |  |
| Behavior problems |  | Measles |  |
| Braces |  | Mental Health Issues |  |
| Brain injury |  | Nightmares |  |
| Cerebral palsy |  | Obturator |  |
| Chickenpox |  | Other surgery: |  |
| Cleft palate/submucous cleft |  | Hospitalization for |  |
| Cochlear implant |  | Physical Abnormalities |  |
| Cognitive Disorder (memory) |  | Poor appetite |  |
| Digestive problems |  | Seizures |  |
| Down’s Syndrome |  | Serious injury: |  |
| Drooling |  | Stuttering |  |
| Dyslexia |  | Swallowing problems |  |
| Ear infections |  | Syndrome (other): |  |
| Encephalitis |  | Thumbsucking |  |
| Falls frequently/balance |  | Tongue-tie |  |
| Feeding/eating problems |  | Tonsillectomy and/or Adenoidectomy |  |
| Frequent colds |  | Tubes in ears |  |
| Glasses |  | Vision problems |  |
| Hand preference R L |  | Vocal nodules |  |
| Head injury |  |  |  |
|  |  |  |  |
|  |  |  |  |

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

**Consent Agreement**

I understand that the Baylor University Speech and Hearing Clinic, hereafter referred to as the Clinic, is operated as a training center for speech-language pathologists and that all therapy conducted at the Clinic is supervised by a certified, 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 video and/or audio 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, 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 recordings 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 Clinic 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)