UA SCIENCE
Speech, Language, & Hearing Sciences

DEPARTMENT OF SPEECH, LANGUAGE, AND HEARING SCIENCES
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THE GRUNEWALD-BLITZ CLINIC FOR COMMUNICATION DISORDERS IN CHILDREN

Child Case History Form

(Speech-Language Pathology)

Please return the completed form to the address or fax above or email it to SLHSClinic@email.arizona.edu.

Name: Date of Birth: Today's Date:

Age: Gender: Pronouns:

Address:

City: State: Zip Code:

Parent 1 Name: Parent 2 Name:

Phone: Phone:

Email: Email:

Referred by: Child's Physician:

Physician Phone:

About your family:	Language:
☐Two parents ☐Single Parent ☐Guardian Ages of Siblings:	Language(s) spoken in the home: Language(s) your child understands: Language(s) your child speaks:

What do you want to find out from us?

School: Grade:

My child has (check all that apply):

☐IEP or IFSP
☐Repeated a grade level
☐504 Plan
☐Difficulties in school
☐Other:

My Child receives the following outside of school (check all that apply):

☐Occupational Therapy ☐Behavioral Therapy
☐Physical Therapy ☐Counseling
☐Other:

Describe any complications during pregnancy:

Describe any medical complications at birth or following birth:

Describe any serious illnesses, accidents, or surgery your child has had:

Has anyone else in your family had a speech, language, or hearing problem?

Describe how your child communicates (sounds, words, sentences, etc.):

When was the last time your child's hearing was tested?

Results available? ☐Yes ☐No

Comments about your child's hearing:

List any food allergies and restrictions:	List any medications your child takes:

My Child's Strengths	My Child's Needs

Please give any other information you believe will help us understand your child:

Signature of person answering questions Relationship to child