Department of Speech, Language, and Hearing Sciences
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THE GRUNEWALD-BLITZ CLINIC FOR COMMUNICATION DISORDERS IN CHILDREN

Child Case History Form (Audiology)

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

Date: ____________________

Child's Name: _________________________________ Date of Birth: ______________ Age: _______________

Gender: _________________________ Pronouns: _______________________

Home Address: ____

City: __________________________________ State: ____________________ Zip Code: __________________

Parent/Guardian 1 Name: _____________________________________ Date of Birth: _____________________

Occupation: ______________________ Email: __________________________ Phone: ____________________

Parent/Guardian Name: _____________________________________ Date of Birth: _____________________

Occupation: ______________________ Email: __________________________ Phone: ____________________

Which is the primary contact? ☐ Parent/Guardian 1 **OR** ☐ Parent/Guardian 2

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

Referred by: ____

Pediatrician's Name: ____ Phone: ___________________

Practice Name: ____ City: _____________________

What do you want to find out from us? ____

____

____

Did the child pass their newborn hearing screening? ☐ Yes ☐ No ☐ Unknown

If no or unknown, please explain: ____

____

____

Other than the newborn hearing screening, when was the last time the child's hearing was tested? Where were they tested, who were they tested by, and what was the result? ___________________________________

____

____

Has anyone in your family ever had a speech, language, or hearing problem as a child? ☐ Yes ☐ No

If yes, please explain: ____

____

EDUCATION & SERVICES

School Name: ____ Grade: _____________________

The child's progress in school is: Excellent Good Fair Poor

The child has (check all that apply):

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

The child receives the following outside of school (check all that apply):

☐ Occupational Therapy
☐ Speech Therapy
☐ Physical Therapy
☐ Other: _____________________________________

Additional services involved with the child (check all that apply):

☐ AZ Hands & Voices
☐ Department of Developmental Disabilities (DDD)
☐ Children's Clinics for Rehab. Services
☐ Other: ___________________________________
☐ Arizona School for the Deaf & Blind (ASDB)
☐ Arizona Early Intervention Program (AzEIP)
☐ Head Start

HEALTH HISTORY

Were there any significant problems during the pregnancy or the delivery or following the child's birth?
☐ Yes ☐ No
If yes, please explain: ____
____
____

Child's birth weight: __________

Has the child had any serious illnesses, accidents, or hospitalizations? ☐ Yes ☐ No

If yes, please describe: ____

____

Do you have any concerns about the child's vision? ☐ Yes ☐ No

If yes, please describe: ____

____

Has the child had repeated ear infections? ☐ Yes ☐ No

If yes, please note when they started, how many they have had, and the date and ear(s) of the last infection:

____

____

Has the child had any ear surgeries? ☐ Yes ☐ No

If yes, please note the type of surgery, when, and which ear:

____

____

The child's general health is: Excellent Good Fair Poor

Please explain any health concerns: ____

____

____

DEVELOPMENTAL HISTORY

At what age, in months, did the child: Sit Alone: ______________ Walk Alone: ___________________

Use first words: _________ Use Sentences: ________________

Describe any unusual slow development: ____

____

While keeping the child’s current age in mind, please rate the following:

Motor coordination and balance: (skipping, hopping, running)	Excellent	Good	Fair	Poor
Eye/Hand coordination: (coloring, drawing, writing)	Excellent	Good	Fair	Poor
General behavior at home:	Excellent	Good	Fair	Poor
Ability to play with other children:	Excellent	Good	Fair	Poor
Ability to keep attention on an activity:	Excellent	Good	Fair	Poor
Ability to play with toys or games:	Excellent	Good	Fair	Poor
Ability to remember people or places:	Excellent	Good	Fair	Poor
Ability to solve problems:	Excellent	Good	Fair	Poor
Ability to follow directions:	Excellent	Good	Fair	Poor
Ability to speak clearly:	Excellent	Good	Fair	Poor

If the child is a preschooler, please answer the following questions:

How many different words does the child use? ____

How many words does the child put together in a typical sentence? ____________________________________

What percentage of the child's speech do you understand?

Less than 20%   20-50%   50-70%   70-90%   Almost all

What percentage of the child's speech would a stranger understand?

Less than 20%   20-50%   50-70%   70-90%   Almost all

____   ____

Printed Name of Person Answering Questions   Signature of Person Answering Questions

____

Relationship to Child