RiteCare Center For Communication Disorders

Armstrong State University
11935 Abercorn Street
Armstrong Center Suite 20
Savannah, Georgia 31419-1997
Phone: 912-344-2969
Fax: 912-344-3439

PLEASE RETURN COMPLETED FORM AS SOON AS POSSIBLE.
YOU WILL BE CONTACTED FOR AN APPOINTMENT
AFTER THIS OFFICE RECEIVES THE FORM.

Case History – Child

Date:_____ Referred by:_____

Person completing this form & relationship to child: _____

Identifying Information

Child's Name: _____ Date of Birth_____

Address: _____
(Street/Route) (City & State) (Zip Code)

Mother's Name: _____ Age_____

Address: _____
(Street/Route) (City & State) (Zip Code)

Place of Employment: _____ Occupation: _____

Phone: _____ Phone: _____ Education: _____
(Home) (Work)

Father's Name: _____ Age _____

Address: _____
(Street/Route) (City & State) (Zip Code)

Place of Employment: _____ Occupation: _____

Phone: _____ Phone: _____ Education: _____
(Home) (Work)

Number of children in family _____ Do any of the other children have special problems? _____

If so, please describe: _____

_____

Revised 4/2015

Birth & Development

Describe any problems before, during or after birth: _____

_____

Was child premature: _____ If so, by how long? _____ Birth weight: _____

Age sat alone: _____ Age crawled: _____ Age walked unassisted: _____

Age toilet trained: _____ Age first words: _____ Age combined words: _____

Education

Name of child's school, kindergarten, or nursery: _____

Teacher's name: _____ Grade: _____

Describe any problems mentioned by teacher: _____

_____

Academic Achievement: Good / Fair / Poor (circle one) What grades (if any) has the child failed? _____

Statement of the Problem

In your own words, describe your child's problem: _____

_____

What do you believe has caused the problem? _____

Has your child ever had: a speech evaluation _____ a hearing evaluation _____

speech therapy _____ hearing therapy _____

Is your child currently receiving speech, language, or hearing therapy? _____

If so, where? _____

Medical Information

Name & address of child's doctor: _____

Has child had any serious illness or operations? _____

_____

Please list any conditions that your child has been diagnosed with by a medical doctor or a psychologist: _____

_____

Please list any medications and dosages that your child is currently taking: _____

_____

Please list any allergies your child has: _____

_____

Please check any of the following that apply to your child with the age when the condition occurred:

___Measles ___Mumps ___Meningitis
___Ear Infections ___Earaches ___Allergies
___High fever ___Influenza ___Pneumonia
___Tonsillectomy ___Seizures ___Sinusitis
___Kidney problems ___Injuries ___Frequent colds
___Visual difficulties ___Balance problems ___Dental problems
___Encephalitis ___Other _____

General Communication

How well does your family understand your child? _____

How well do strangers understand your child? _____

Did your child acquire speech and then slow down or stop talking? _____

If so, when and why? _____

Has your child had chewing or swallowing difficulties? _____

If so, describe _____

Check any of the following statements that apply to your child:

_____ Follows directions well

_____ Seems to understand what is said to him/her

_____ Needs to look at person speaking in order to understand

_____ Imitates speech of others but doesn't initiate speech

_____ Uses little or no speech

_____ Talks too fast

_____ Talks too slow

_____ Stutters or stammers

_____ Uses complete sentences

_____ Speech is difficult to understand

_____ Depends on signs and gestures instead of speech

Voice is: ___hoarse ___nasal ___too high ___too low ___too loud ___too soft

What sounds do you notice that your child responds to? (Ex. doorbell, footsteps, phone, etc.)

_____

How do you communicate with your child? _____

Does hearing appear to be constant or does it vary? _____

Has your child ever worn a hearing aid? _____
(NOTE: If your child has a hearing aid, please bring it and the earmold with you to the appointment.)

General Behavior

Check the following that apply to your child:

_____ Difficulty concentrating

_____ Under active

_____ Overactive

_____ Difficult to manage

_____ Prefers to play alone

Please make any additional comments that you think may help us in working with your child

_____

_____

Please list any other evaluations your child has had and/or other agencies currently serving your child:

_____

_____

_____

Please read and sign:

Revised 4/2015

I understand that the Armstrong State University RiteCare Center Communication Disorders Clinic is a training facility for student-clinicians in the Speech-Language Pathology Program. I understand that student-clinicians under the supervision of a licensed, certified Speech-Language Pathologist render communication diagnostic and therapy services. I authorize the Armstrong State University RiteCare Center Communication Disorders Clinic to provide services to my child.

_____ _____

(Signature of parent or legal guardian) (date)

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