Whisper Hearing Centers

*Hear from the experts.*

# CHILD CASE HISTORY

**NAME:** _____ **DOB:** _____ **DATE:** _____

**AUDIOLOGIST:** _____ **PHYSICIAN:** _____

**REASON FOR VISIT:** _____

**FORM COMPLETED BY:** _____

**SIBLINGS (NAME & AGE):** _____

## HEARING HISTORY

1. Did your child pass his/her newborn hearing screening? Y N
   If no, was follow-up testing completed? Y N Facility? _____ Results? _____
2. Has your child been seen by a physician about his/her hearing or ears in the past? Y N
   If so, physician name and reason _____
3. Does anyone in your family have hearing loss other than natural aging? Y N
   If yes, please explain _____
4. Do you feel your child has any hearing problems? Y N
   If yes, please explain _____
5. Does your child consistently respond to your voice? Y N
6. Does your child respond to loud noises? Y N
7. Has your child's hearing ever been tested? Y N
   If yes, Facility? _____ Results? _____

## PREGNANCY AND BIRTH HISTORY

1. Was the pregnancy normal? Y N
   If no, please explain _____
2. Was the delivery normal? Y N
   If no, please explain _____
3. Was the delivery premature? Y N
   If yes, week of delivery _____
4. Did the mother have any illness during the pregnancy? Y N
5. After birth, did your child have any of the following:
   - Breathing difficulties? Y N
   - Any head, neck or ear abnormalities? Y N
   - Surgery? Y N
   - Any infections requiring medication? Y N

**MEDICAL HISTORY**

1. Does your child have any medical concerns or conditions? Y N
   If yes, please explain _____
   _____
   _____
2. Please check if your child has had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Ear infections | ☐ | Meningitis | ☐ | Seizures | ☐ |
| Ear surgery | ☐ | Measles | ☐ | Kidney problems | ☐ |
| Hospitalization | ☐ | Mumps | ☐ | Vision problems | ☐ |
| Head Trauma | ☐ | Chicken Pox | ☐ | Allergies | ☐ |

3. Please list all current medications your child is taking: _____
   _____
   _____
   _____

**SPEECH, LANGUAGE AND DEVELOPMENTAL HISTORY**

1. Do you have any concerns about your child's speech and language? Y N
2. Is your child's speech understood by:
   Parents ☐ Yes ☐ No Siblings ☐ Yes ☐ No Other adults ☐ Yes ☐ No
3. Has your child's speech or language ever been evaluated? Y N
   If yes, please explain _____
4. Is your child currently receiving speech therapy? Y N
5. How does your child usually communicate (check all that may apply)?
   - ☐ Babbling (e.g., "ba,ba")
   - ☐ Single Words
   - ☐ 2-3 word utterances
   - ☐ Sentences
   - ☐ Conversations
6. Do you have any concerns about your child's physical development? Y N
7. Does your child lose their balance or fall easily? Y N
8. About what age did your child :
   Sit unsupported _____
   Crawl _____
   Walk alone _____

**EDUCATION HISTORY**

1. Is your child currently attending:
   - ☐ Day care
   - ☐ Preschool
   - ☐ Elementary school
   - ☐ Middle school
   - ☐ High school

   Where: _____
   Number of hours per week: _____
   How is your child doing in the program? _____
2. Does your child receive any special services at school? If yes, please describe: _____
   _____
3. Do you have any concerns about your child's behaviors at school? If so, please describe: _____
   _____