THE UNIVERSITY OF SOUTHERN MISSISSIPPI

SCHOOL OF SPEECH AND HEARING SCIENCES
118 College Drive #5092 | Hattiesburg, MS 39406-0001
Phone: 601.266.5232 | Fax: 601.266.5224 | www.usm.edu/shs

APPLICATION FOR ASSESSMENT

Child Case History – Speech/Language Date: _____

Please complete this form for our clinical faculty to plan a thorough assessment. It is important to answer each applicable question as accurately as possible. Please return the form to the Speech-Language Pathology Clinic at the above address so we can schedule your appointment.

GENERAL INFORMATION:

Child's Name: _____ DOB: _____ Gender: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Email:_____

Occupation: _____ Employer: _____ Phone: _____

Parent/Guardian: _____ Email: _____

Occupation: _____ Employer: _____ Phone: _____

Primary language spoken in the home: _____Referred to this clinic by: _____

Pediatrician: _____

STATEMENT OF CONCERN:

Describe concerns about your child's communication skills (fluency, articulation, language, voice).

_____

_____

_____

When was the concern first noticed? By whom? _____

Describe how your child communicates (check all that apply)

____ pointing, gesturing, vocalizing
____ communication board/device
____ three- or four-word phrases
____ eye contact, facial expressions
____ single words
____ full sentences/conversation
____ babbling
____ two-word phrases

Does your child communicate in order to (check all that apply)

____ ask for wants/needs ____ ask questions/make requests ____ seek your attention
____ greet people ____ask for help ____ share information

MEDICAL & BIRTH HISTORY:

Describe mother's general health during pregnancy (illnesses, accidents, medications):

_____

_____

Was the child full term or premature? _____

Did your child spend time in NICU (if yes, how long?) _____

Any problems at birth or during first 2 weeks (jaundice, anoxia, weight, etc.):

_____

_____

Provide approximate age for the following illnesses, operations, conditions, and/or diagnoses?

Earaches: _____
Seizures: _____
Chronic colds: _____
Head injuries: _____
Chicken Pox: _____
Pneumonia: _____
Influenza: _____
GI Issues: _____
Feeding Disorder: _____
Diabetes: _____

Asthma: _____
Tonsillitis: _____
Tonsillectomy: _____
Adenoidectomy: _____
Cleft Palate/Lip: _____
ADHD: _____
Meningitis: _____
Sinus Problems: _____
Cancer: _____
Traumatic Brain Injury: _____

List any surgeries, hospitalizations, and/or accidents:

_____

_____

List any medications taken by your child: _____

_____

What is the child's current overall health status?_____

_____

Does child have any medically diagnosed conditions or genetic syndromes? _____

_____

SPEECH-LANGUAGE HISTORY & DEVELOPMENTAL MILESTONES:
Provide approximate age for the following:

Skill	Age achieved
Sat independently	
Crawled	
Walked unaided	
Babbled	
First meaningful word	
Combined two words	
Dressed self	
Toilet trained	

Did speech learning ever seem to stop for a period? _____

Has there been a change in speech in the last six months? (Describe) _____
_____
How many words are presently in the child's vocabulary? ____Under 25 _____ 25-50 _____ Over 50

Does child use speech frequently? _____ Is child aware of speech difference? _____

Does your child communicate with any form of AAC? If so, describe: _____

How much of your child's speech do you understand? ____0-25% ____ 25-50% ____ 50-75% ____ 75-100%
How much do others understand? ____0-25% ____ 25-50% ____ 50-75% ____ 75-100%

Check all that apply: ____ names simple objects ____ asks simple questions/makes requests

DAILY BEHAVIOR:
Sleeping problems? (Explain) _____
Difficulty concentrating? _____
Difficulty with change? _____
How does the child interact with others? _____
Describe the child's favorite play activities: _____
_____
Describe any atypical behavior: _____

EDUCATIONAL HISTORY:
School: _____ Grade: _____Does child receive special services _____

Speech Pathologist: _____

What are the average grades: Reading: _____Spelling: _____Language: _____

Repeat or Skip grade level: _____ Did child attend headstart/prek/daycare _____

FEEDING:
Does your child have difficulty chewing or swallowing: _____

Has your child ever received feeding via an alternative non-oral means? _____

If so, please describe: _____

Has your child ever received VFSS/MBS/FEES (swallow study)? If so, report results: _____
_____

Does your child feed themselves_____ independently or ____with assistance:
Does your child use utensils ____independently or ____with assistance:
Does your child require special positioning during mealtimes? _____
Does your child enjoy mealtimes? _____
Choose which method used for liquid consumption:
____ Bottle fed
____ sippy cup (what kind?)
____ open cup
____ straw
____ water or sports bottle
Check the kinds of food your child eats:
____ smooth purees
____ purees with lumps or textures
____ fork mashed
____ Food cut up into bite sized pieces
____ regular table foods without modifications
Check if your child exhibits any the following:

____ Choking during meal (specific food or liquid)	____ gagging	____ difficulty chewing
____ coughing during meals	____ food refusals	____ holding food in mouth
____ wet or gurgly voice during or after eating	____ mouth sensitivity	____ stuffing mouth too full

Do certain foods or liquids appear to be more difficult to consume? _____
_____
List any adaptative feeding equipment used (chairs, utensils, cups): _____
_____

HEARING:
Does child look at family members when they are named? _____

Does child point to common objects when asked “Show me the _____?” or “Where is the _____?

List most current Audiological evaluation or screening date and results: _____
_____

Does child follow multi-step directions? _____

PLEASE CHECK THE APPROPIATE ANSWER:	YES	NO
Generally indifferent to sound:	( )	( )
Lack of response when spoken to:	( )	( )
Responds to noise, not voice:	( )	( )
Turns devices too loud, talks too loud or too soft:	( )	( )

ENVIRONMENTAL BACKGROUND:
List any familial medical/education concerns: reading problems, intellectual disability, mental illness, learning disabilities, neurological disorders, speech disorders, vision problems? Please describe:

_____

_____

PREVIOUS ASSESSMENTS:
Please bring copies of all reports or IEPs

Has your child received any of the following assessments? Please indicate:

_____ Hearing _____ Speech and Language _____ Psychological _____ Neurological

_____ Occupational Therapy _____ Physical Therapy _____ Vision _____ Developmental

If so, please state when the assessment was conducted, by whom and for what reason:

Type of Exam	Date	By Whom	Reason for Exam

_____

_____

_____

If we have permission to request these reports, please sign here.

Signature: _____ Date: _____

Please provide any additional information that might be helpful in the assessment of your child:

_____

_____