FONTBONNE UNIVERSITY

Department of Communication Disorder and Deaf Education

Eardley Family Clinic for Speech, Language and Hearing

You have requested a speech/language evaluation or therapy. Attached you will find a case history form. Answer the questions as fully and accurately as possible. If you have an IEP or diagnostic report from another institution, please attach a copy. This information will assist the clinic staff in planning and providing for your evaluation or therapy.

Return all forms to the speech clinic as soon as possible. We will call you to schedule an appointment. All evaluations and therapy sessions are conducted by graduate students under the direct supervision of a faculty member or supervisor. All faculty members and supervisors have valid Missouri licenses and ASHA certification.

We offer speech/language evaluations and speech language augmentative communication evaluations as well as therapy for all types of communication disorders. Evaluations are needed if there is no current evaluation or assessment by an ASHA certified speech pathologist.

Individual therapy is offered for all ages. This therapy is typically provided two days a week
(Mon & Wed or Tues & Thurs) for one hour each day.

Developmental Language Group (DLG) – This is a group of 6-8 children ages 2-5. We have 3 or 4 clinicians who work within the group. The group runs in the fall, spring and summer, 4 mornings a week, for 2 hours each morning usually form 9:00-11:00 AM.

We also have communication groups for individuals with Aphasia.

There are no fees for evaluations or therapy services.

CASE HISTORY

Date_____

Name of Child _____
First Middle Last

Birth date_____ Age_____

Address_____ City_____ State/Zip_____

Parent Name(s) (1)_____

Parent Phone (1): Home_____ Work_____ Cell_____

Email_____

Parent Name(s) (2) _____

Parent Phone (2): Home_____ Work_____ Cell_____

Email_____

Contact information of any parent/guardian that differs from the child:

_____ _____ _____ _____
Street Address City State/Zip Phone/Email

Names of other children/individuals living with the child
Name Age Relationship

Medical Information:
Indicate the physician who is best acquainted with the child.
Name_____ Phone_____
Address_____
Is there a physical condition such as: cleft palate, paralysis, mouth deformities, etc.?
Please indicate.

Is there any significant medical history, such as difficulties at birth, seizures, unusual or prolonged illnesses, etc.? Please explain.

Does your child use a wheelchair? _____ If yes, what type?_____
Does he/she use this wheelchair at all times?_____

Does your child have difficulty using his/her hands?_____ If yes, please describe._____

Has your child used any strategy or device to help him/her communicate?_____
If yes, please describe._____

Other medical treatment, if so, please explain._____

Therapy History:
Has your child previously and/or currently received any therapy ? (speech, occupational, or physical) Yes ____ No_____
If yes, please indicate type, location, and approximate dates.

Type:_____ Location: _____ Dates:_____
Type:_____ Location: _____ Dates:_____
Type:_____ Location: _____ Dates:_____
Type:_____ Location: _____ Dates:_____
Type:_____ Location: _____ Dates:_____

Hearing History:
Does your child have a history of multiple ear infections? _____
If so, how were these treated?

Does he/she seem to have any difficulty hearing (TV too loud, does not respond to name)?

Has he/she been diagnosed with a hearing loss? No____ Yes____ If yes,
Mild _____ Moderate _____ Severe _____ Profound _____

Does the child have: Hearing Aids ___ Cochlear Implant ___ Surgery ___
Academic History:
School _____ Current Grade _____
How well does your child function in school? _____
How well does your child follow directions?_____

Any associated concerns (learning disabilities, reading delay, auditory processing, etc.)

How does your child get along with his peers?_____
Who does your child interact with most often and what kinds of activities do they do together?_____
_____

Developmental History:
Did your child have any delays in: talking ___sitting ___ crawling ____ walking ____
Were there any nursing/feeding difficulties (sucking, swallowing, drooling, chewing)?
_____
Describe any delays or difficulties with development.

Speech/Language Information:
Description:
Is speech understandable? __ Are sounds omitted? __ Substituted? ___ Distorted?___
Is the voice quality noticeably different from other children? ____
Does he/she speak too rapidly? ____
Does he/she stutter? ____
Does he/she understand most things he/she hears? ____
Does he/she understand more than he/she says? ____
Does he/she talk in single words?___ 2-3 word utterances? ___ complete sentences?___
Does he/she use specific words to name things? ___
Please describe or give examples from any of the areas noted above.

Has your child ever spoken better than he/she does now? _____
Did he/she start talking and then stop? _____
Is he/she aware of his communication difficulties? ____
Are any languages spoken in the home besides English? ____ If so, what? _____

Please describe any other concerns relating to speech/language development.

Please describe your concerns about your child's communication.

Has your child received a speech/language evaluation?
Location_____ Date _____
Results/Recommendations:

Does your child have a current IEP/IFSP? Yes____ No____

Person Completing Form _____ Relationship to child_____

Who referred you to this clinic?_____

All information is for the confidential use of the Fontbonne University Speech/Language Clinic staff only.

Revised July 28, 2011