

UNIVERSITY OF CENTRAL ARKANSAS
Speech-Language-Hearing Center
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LITERACY CASE HISTORY

General Information

Instructions: It is important that you fill out this form as completely as possible. If you need more space, please use the back of the form.

Date: _____

Person completing this form: _____

Relationship to child: _____

Referred by: _____

Name of the Child: _____ Preferred name: _____

Birthdate: _____

Gender: _____

Address: _____

Home Phone: _____

Work Phone: _____ Cell: _____ email: _____

Mother's Name: _____

Father's Name: _____

Individuals living in the home: _____

Child's Guardian/Primary Caregiver, if not parent: _____

Father's Occupation: _____

Mother's Occupation: _____

Names and ages of brothers and sisters of the child:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Name and address of child's doctor: _____

Presenting Complaints

1. In your own words, describe what concerns you about your child.

(If more space is needed please use reverse)

2. When was this problem first noticed? _____

3. How was this problem first noticed? _____

4. What do you believe has caused the problem? _____

5. What has been done about the problem? (If the child has had previous speech, language, or hearing examinations or therapy, please tell where, when, and by whom, and what recommendations or treatment was given). _____

6. What changes, if any, have you noticed in the child's hearing or general condition recently? _____
7. Is the child aware of this problem? If yes, how do you know? _____

Physical-Medical History

1. Was this child your first pregnancy? If not, what number is he/she? _____
2. What did you notice to be irregular about your pregnancy (i.e. German measles, bleeding, rashes, chicken pox, injuries, illnesses, Rh compatibility, false labor, anemia, etc.)? _____

3. What medication, if any, were used during this pregnancy? _____

4. What was the length of this pregnancy and the duration of labor? _____

5. Type of delivery: __Normal __Breech __Caesarean
6. Anesthetics used during delivery: _____
7. Color of baby at birth:
- __Normal Red __Abnormal Red __Yellow
- __Blue __Purple __Other
8. Were there any bruises, marks, discolorations, or abnormalities at or following birth? _____
9. Birth Weight: _____
10. Did this child require any special attention while in the hospital? _____
11. How old was the child when he/she left the hospital? If longer than 3 days explain. _____
12. Name and address of hospital where this child was born: _____
13. Were there any feeding difficulties following birth: (sucking, chewing, swallowing)? _____
14. History of illnesses: Please indicate the age at which the illness occurred.
- Measles
 - Visual Difficulties
 - Whooping Cough
 - Scarlet Fever
 - High Fever
 - Influenza
 - Convulsions
 - Frequent Colds
 - Mumps
 - Allergies
 - Epilepsy
 - Tonsillitis
 - Sinusitis
 - Head Injuries
15. Has this child ever been examined by a neurologist? If so, what were the findings? _____
16. Has this child ever been hospitalized since birth? If so, when and for what reason? _____
17. At approximately what age did this child sit and walk alone? _____
18. Is this child toilet trained? _____ At what age? _____

19. Is this child able to pick up a small object, such as a wooden block or bead, and hold it in his/her hand? _____
20. Do you feel that this child's physical coordination is appropriate for his/her age? If not please explain. _____

Speech and Language Development

1. Do you remember this child lying in his crib and making play type sounds, such as cooing and/or babbling? _____
2. Do you remember this child attempting to copy or mimic words of others? _____

3. Does anyone in the family have a hearing problem? If so, what relation are they to this child? _____
4. At what age was this child when he/she said his/her first meaningful word? _____
5. What was it? _____
6. Used phrases? _____
7. Used sentences? _____
8. Are there some words that this child appears to understand but cannot say, such as bye-bye, baby, no, cookie, bath, etc.? _____

9. How does he/she show that he/she understands them? _____

10. Check any and all statements which most accurately describe this child's present speech and language behavior:

- Follow directions well
- Seems to understand what is said to him/her
- Appears to have difficulty hearing
- Needs to look at the person speaking in order to understand
- Seems to be unaware of sounds in the environment
- Rarely attempts speech
- Depends primarily on signs and gestures instead of speech
- Attempts speech but is difficult to understand
- Uses speech sounds incorrectly
- Leaves out words or confuses word order
- Stammers or stutters
- Talks to fast or too slow (circle one)
- Uses an abnormal voice quality
- Uses abnormal pitch level
- Uses complete sentences
- Uses only phrases
- Uses no speech
- Comments:

Auditory Behavior

1. To what sounds do you notice this child respond? (i.e. doorbell, footsteps, phone, dial tone, hand clap, soft sounds, loud sounds, vibrations, any speech sounds, etc.) _____

2. Does he/she consistently respond to his/her own name when called or other speech sounds when not facing the speakers? _____
3. How do you communicate with each other? _____

4. Who best understands this child at home? _____
5. Does this child seem to watch your face for communicative clues? _____

Social-Emotional Development

1. Below is a list of words which describe children’s personality and behavior. Please check those which you feel tend to describe your child.

- | | |
|--|---|
| <input type="checkbox"/> Sad | <input type="checkbox"/> Follower |
| <input type="checkbox"/> Moody | <input type="checkbox"/> Very Active |
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Leader | <input type="checkbox"/> Hard to discipline |
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Has temper tantrums |
| <input type="checkbox"/> Independent | <input type="checkbox"/> Affectionate |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Even tempered | <input type="checkbox"/> Has trouble sleeping |
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Sucks thumb |

2. Is this child easily managed at home? _____
3. Would you describe this child as “usually” active? _____
4. Would you describe this child as “usually” distractible? _____

Educational History		
Educational Setting	Location/School	Teacher(s)
Child Care Facility		
Early Childhood Classes		
Birth to 3 Program		

5. How often does your child attend classes?

<input type="checkbox"/> daily	<input type="checkbox"/> 4 times per week	<input type="checkbox"/> 3 times per week
<input type="checkbox"/> 2 times per week	<input type="checkbox"/> ½ days	<input type="checkbox"/> full day

6. How many children are in your child's class? _____
7. What type of classroom is your child in? (i.e., traditional, open classroom, transdisciplinary, etc.) _____
8. Does your child exhibit any learning style preferences?

Visual Auditory Both

9. Does your child's developmental performance seem to interfere with his/her school performance? Yes No

If "Yes," please explain: _____

10. Have teachers expressed any concerns about your child's learning behavior?

Yes No

If so, please describe: _____

11. Has your child ever repeated a grade? If so, what grade? _____

12. What are your child's academic strengths and/or best subjects? _____

13. Is your child having difficulty with a particular subject? _____

If yes, what subject? _____

14. Is your child receiving help at school or at home (i.e., support services, tutoring, etc.)? Yes/No: If yes, please explain: _____

15. Has your child ever been evaluated for or attended therapy for:

speech problems vision problems feeding problems
 hearing problems physical motor problems

Other _____

Please give locations, dates, and results.

The UCA Speech Language Hearing Center shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, or dialect.