VALDOSTA STATE
Building for Our Next Century

Valdosta State University is an equal opportunity educational institution. It is not the intent of the institution to discriminate against any persons based on the sex, race, religion, color, national origin or handicap. It is the intent of the institution to comply with Title VI of the Civil Rights Act of 1964 (and subsequent executive orders) and Title XI in Section 504 of the Rehabilitation Act of 1973.

PLEASE RETURN COMPLETED FORMS AS SOON AS POSSIBLE. YOU WILL BE CONTACTED FOR AN APPOINTMENT UPON RECEIPT OF THESE FORMS.

CASE HISTORY- CHILD

Appointment for: (circle one) Speech/language Hearing

Date:_____ Referred by: _____

Person completing this form and relationship to child: _____

Identification

Child's Name _____

Date of Birth _____ Age _____ Sex _____

Address _____
(street/route) (city & state) (zip)

Mother's Name _____ Age_____

Address_____

Place of Employment _____ Occupation _____

Phone _____ Phone _____ Education_____
(home) (work)

Father's Name_____ Age_____

Address_____

Place of Employment _____ Occupation _____

Phone _____ Phone _____ Education_____
(home) (work)

see reverse side: page 1

Email address (optional): _____

Emergency Contact/Name: _____ Ph# _____

Siblings of Client: (names/ages) _____

Race/Ethnicity (for statistical purposes): _____

Any speech/hearing problems in the family?_____ If so, describe _____

Has the child ever been diagnosed as having any of the following? (check any that apply)
A syndrome _____ Autism _____ Intellectual Disability _____
Learning Disability _____ ADD/ADHD _____ Other _____

Medical Information

Name and Address/Phone of child's doctor_____

Does the child have any allergies (food, latex, others)? Please list: _____

_____

Has the child ever had any serious illnesses or surgeries? If so, describe _____

_____

Please check any that apply and give the age when the condition occurred:

Meningitis _____Influenza _____ Seizures _____
Ear Infections _____ Earaches _____ Allergies _____
High Fever _____ Pneumonia _____ Sinusitis _____
Tonsillectomy _____ Balance Problems _____ Dental Problems _____
Kidney Problems _____ Injuries _____ Frequent colds _____
Visual Difficulties _____ Other _____]TJ ET EMC /P <MCID 7

Is child tab2.04 38.5Tm[ )]TJ ET EMC /P 427g27g27g27g2[ )]TJ ET3dic(s ____he)4(s __(0that a)F)6(re)(7]TJwT ____h

Child's Voice is: (check any that apply)
hoarse ( ) nasal ( ) too high ( ) too low ( ) too loud ( ) too soft ( )

Hearing:
What sounds does your child respond to? _____

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

Any concerns about child's hearing? _____ If so, describe _____

_____

Has the child ever worn a hearing aid?_____ If so, describe type, benefit, etc _____

_____

NOTE: if your child has a hearing aid, please bring it to the appointment.

General Behavior

Check any that apply to your child:

Difficulty concentrating _____
Overactive _____
Difficult to manage _____
Prefers to play alone _____

Please add any comments/information that may help us in working with your child:

_____

Please read and sign:

I understand that the Valdosta State University Speech and Hearing Clinic is a training facility for student clinicians in the Communication Disorders Program. I understand that student clinicians under the supervision of licensed professionals render diagnostic and therapy services. I authorize VSU Speech and Hearing Clinic to provide services to my child.

_____ _____

Signature of parent or legal guardian **Date**

Revised 3/13