PennState
Department of Communication Sciences and Disorders
The Pennsylvania State University
110 Ford Building
University Park, PA 16802-3000

Clinic: 814-865-5414
Voice/TDD
Department: 814-865-3584
Fax: 814-863-3759

Pediatric Case History Information

The Cost of the initial speech and language assessment is $*150.00* which includes the assessment, the discussion of assessment results and recommendations, and a written report. Payment should be discussed with the Clinical Administrative Support Assistant prior to your appointment, but generally will be due on the day of the assessment. The PSU clinic does bill a few (but not all) insurance companies. For those clients who are insured through companies we do not directly bill, you will be provided with a copy of the billing information which will include the fee paid, the diagnosis and the code for that diagnosis. If you wish to pursue reimbursement, you can then submit the claim to your insurance company directly.

The Penn State Speech and Hearing Clinic is not a Medicaid/Medical Assistance provider. Therefore, we are not able to accept referrals that are affiliated with any Medical Assistance plans. If you plan to schedule the assessment, you will be responsible for payment the day of the assessment.

For clients covered by Geisinger Health Plan (GHP): Prior to the assessment you will need to ask your physician for a referral letter and prescription for a speech/language evaluation. The referral letter, prescription, and insurance card must be provided to the Clinical Administrative Support Assistant at the Penn State Speech, Language, and Hearing Clinic at least two weeks prior to the assessment to insure authorization of the services by GHP. You may fax this documentation to 814-863-3759, or deliver the documents to 110 Ford Building, University Park, PA 16802. The clinic will bill GHP directly. It is likely that your GHP policy will require a co-pay payment. This co-pay will be collected at the time of the assessment.

In preparation for your speech-language evaluation, please answer the questions on the attached Case History form, and return this form to the Penn State Speech and Hearing Clinic at 110 Ford Building, University Park, PA 16802 or fax to 814-863-3759. The information you provide on this form is confidential and will aid us in planning a thorough evaluation.

Date: _____

Person to be evaluated

Name:	Date of Birth:
Parent(s) Names:	
Address:	Present Age:
	Sex:
Phone number:	Nickname:
Email address:	Grade:
Cell phone number:	School:

Family Information / People with Whom the Child Lives

Father's Name and Age:	Occupation:
Mother's Name and Age:	Occupation:
Siblings Names and Ages:	
Others in the household:	

List significant activities, interests, events, hobbies, favorite toys, etc. for this child.

Who typically takes care of your child?

Daycare _____ Frequency and Duration _____

Preschool _____ Frequency and Duration _____

With whom does the child live?

Name:	Address:
Phone number:	

Person filling out this form

Name:	Relation:
Address:	Phone:

Child referred by

Name:	Relation:
Address:	Phone:
Reason for Referral:	

Statement of Concern (Please describe your child's speech and language as fully as possible):

1. When was this concern first noticed? _____
   By whom? _____
2. What do you hope to learn from this evaluation? _____
   _____
3. Why are you seeking services at the Penn State Speech and Hearing Clinic at this time? _____
   _____

Please list other family member(s) who have a hearing loss (before age 50) or speech/language or learning difficulties (brothers, sisters, mother, father, and extended family such as grandparents, cousins, etc.):

Prenatal (pregnancy), Birth, and Development

1. **Prenatal**

Mother's age when child was born _____ Father's age when child was born _____ Length of pregnancy in weeks _____
Birth weight _____ One minute Apgar _____ Five minute Apgar _____
How long was the infant's stay in the hospital following birth? _____

Yes	No	*If any questions are answered "yes", please provide additional information below.*
		Did the mother experience bleeding during pregnancy?
		Did the mother have measles during pregnancy?
		Did the mother have high blood pressure during pregnancy?
		Did the mother experience leakage of membranes during pregnancy?
		Were there complications (e.g., anemia, dehydration, diabetes, kidney infection, severe nausea, toxemia, accidents, etc.) during this pregnancy?
		Were prescription/non-prescription drugs (including alcohol) taken during pregnancy?

2. **Birth**

Yes	No	*Other than the 1st question, if any questions are answered "yes", please provide additional information below.*
		Did the mother have a vaginal delivery with this child?
		Did the mother have a breech delivery?
		Did the mother have a Caesarean Section delivery?
		Were there birth injuries?
		Were there breathing difficulties (e.g., blue baby, required oxygen, stopped breathing, apnea, other_____)
		Were special instruments used during delivery?
		Was the baby jaundiced at birth?
		Was there Rh incompatibility?
		Were there any problems or complications following birth or during the first two weeks of your infant's life (feeding, seizures, sleeping, swallowing, hospitalizations, etc.)?

3. **Development** (give age when first occurred)

Age	**Motor Skill**	**Age**	**Motor Skill**
	Held head up		Fed self with spoon
	Sat up unsupported		Bladder Trained
	Reached for object		Bowel trained
	Crawled		Dressed Self

	Stood alone		Undressed Self
	Walked alone		

What motor &/or self-help development concerns do you have for this child? _____
_____

Would you describe your child's coordination as: _____ good _____ fair _____ poor
Explain: _____
_____

Child's Medical History

Child's pediatrician / primary care physician

Name:	Address:
Phone number:	

Please check all conditions that your child has had or presently has: **General**

___allergies ___ asthma ___ blood disease
___chicken pox ___ convulsions ___ crossed eyes
___croup ___ dental problems ___ diphtheria
___encephalitis ___ epilepsy/seizures ___ apraxia
___headaches ___ head injury ___ dysarthria
___heart problems ___ high fevers ___ influenza
___measles ___ meningitis ___ mumps
___muscle disorder ___ nerve disorder ___ traumatic brain injury
___pneumonia ___ polio ___ bronchopulmonary dysplasia ___rheumatic fever ___ cerebral palsy
___ tracheostomy
___whooping cough ___ stroke ___ RSV
___ neonatal drug dependence ___failure to thrive ___ CMV (Cytomegalovirus)
___ fetal alcohol syndrome ___feeding or swallowing ___ HIV
___ gastroesophageal reflux problems ___Others
(list below)

_____
_____

Child's Visual Status

1. Does your child wear glasses? ___ yes ___ no
2. Does your child have any visual problems? ___ yes ___ no If so, describe, including any accommodations necessary within the classroom:

   _____
   _____

3. Date of most recent vision testing

   _____

4. Where was the testing done? _____
5. By whom was the testing performed? _____

Ear, Nose, and Throat

Please check all conditions that your child has had or presently has:

___ chronic cough/colds	___ hoarse voice	___ difficulty swallowing
___ tonsillitis	___ tonsillectomy	___ adenoidectomy
___ tongue deformity	___ jaw deformity	___ cleft palate/lip
___ speech problem	___ ear deformity	___ dizziness
___ too much wax in ears	___ pressure equalization tubes	

Please list any medications the child is taking presently: _____

_____

If your child has been seen by a medical specialist, hospital, clinic, agency, etc., please list below:
Agency/Specialist _____ Date _____
What was done? _____
Results/Recommendation _____

Child's Communication Skills

Speech Production: Check and provide examples / descriptions where applicable

	Sounds are not produced at all (e.g., "look" is pronounced as "ook")
	Sounds are substituted for with other sounds (e.g., "cat" is pronounced as "tat")
	Sounds are not produced clearly (e.g., "s" sounds slushy)

Expressive Language: Check and provide examples descriptions where applicable

Yes	No	*If any questions are answered "yes", please provide additional information.*
		Are languages other than English (including sign language) used at home?
		Did the child begin to babble or talk and then stop?
		Child is not talking, but may be using gestures.
		Child is only saying a few words.
		Child is talking, but only puts a few words together at a time.
		Child is talking, but there are errors in grammar.

1. Please indicate all means of communication currently used:

___Speech	___ Vocalizations	___ Bodily Gestures
___Facial Gestures	___ Gestural (yes/no)	___ Takes person to item
___Spoken (yes/no)	___ Manual Signs	___ Pointing

___Augmentative Communication Device

List any adaptive equipment currently used and describe your child's ability to communicate with the device:

_____

_____

2. At what age did your child say his/her first word? _____
What were the child's first few words?
_____

3. Approximately how many words did the child have at
18 months? _____ 24 months? _____

4. At what age did the child say his/her first sentence? _____
Please give some examples of first sentences:
_____ Please give some examples of phrases/
sentences your child typically uses now: _____
_____

5. How often does your child use speech? ___ Frequently ___ Sometimes ___ Rarely

6. How does your child make his/her needs known? _____

7. Does the child use gestures often? ___ yes ___ no if so, give an example _____
_____

8. What does the child use the most?
___Gestures ___ Sounds ___ One or two words ___ Phrases ___ Complete sentences

9. Estimate the percentage of time that the child is understood by:
___Unfamiliar listeners ___ Parents ___ Other adults ___ Brothers and Sisters ___ Friends

Receptive Language: Check and provide examples descriptions where applicable

11. How well does the child understand what is said to him/her? _____

	Understands gestures
	Does not understand spoken words
	Understands single words
	Understands simple sentences
	Understands / follows 1step directions
	Understands / follows 2 step directions
	Understands / follows 3 step directions
	Understands conversation

Voice: Check and provide examples descriptions where applicable

	Voice sounds consistently hoarse
	Voice sounds like child has a cold
	Voice sounds like child is talking through his / her nose

Fluency: Check and provide examples descriptions where applicable

	Child repeats sounds or words when talking
	Child has trouble getting the sentence started
	Child has changes in pitch when having trouble talking
	Child shows signs of awareness of his/her difficulty talking
	Child has tension, facial grimaces, etc.

Do you think the child is aware of his/her communication difference? ___ yes ___ no
If yes, please describe how the child shows awareness. _____
_____
_____
_____

Provide any other information about your child's communication that is of concern to you.
_____
_____
_____

What have immediate family and/or relatives done to help the child overcome his/her communication difficulty?
_____
_____

Has this helped? _____
What do you think caused this communication difference? _____
_____
_____
_____

Please provide any additional information you feel will help us in understanding the child and his/her present communication ability. _____
_____
_____

Child's Hearing Status

Date of most recent hearing evaluation _____ Results _____
Where was testing performed? _____
By Whom? _____

Yes	No	
		Do you feel that the child hears well?
		Has the child ever been exposed to a loud noise or explosion?
		Has the child ever had an ear infection? If so, which ear? Last occurrence _____First occurrence _____Frequency_____
		Does the child presently have or in the past had draining ears (pus, blood, etc.)?
		Does the child ever complain of ear noises (tinnitus) such as ringing, buzzing, pulsing, etc.?
		Is the child able to locate the direction from which sound is coming?
		Does your child hear the same from day to day?
		Does your child favor one ear? If so, which ear?
		Does your child respond to vibration caused by loud sounds (door slam, truck driving by, airplane, radio in car, boom box vibration, etc.)?
		Does your child watch the speaker's face when listening?
		Does your child wear hearing aids? Right ear_____ Left ear_____ Both ears_____ Make and Model _____ How long has he/she worn hearing aids? _____ How many hours a day does your child wear the hearing aids? _____

Child's Educational History

Does your child attend ___ day care ___ kindergarten ___school ____ other

Name of School	
Current Grade	
Type of Class	(e.g., regular education classroom, FT learning support classroom, autism classroom, etc.)
Address	
Phone	
Teacher	
Speech Language Pathologist	
Name of Principal	

Previous Schools Attended:

Name of School	Address	Dates Attended

Current grades for: Reading _____ Language _____ Spelling _____ Math _____

Child's Cognitive History

Psychological Evaluation Completed: _____
Date of most recent test: _____ Where tested: _____
By Whom? _____ Test Results and Recommendations:
_____
_____
*Please provide us with a copy of the Evaluation Report.

Other Services Currrently or Previously Provided

Has your child been evaluated by another professional?
Type of Evaluation Completed: _____
Date of most recent test: _____ Where tested: _____
By Whom? _____ Test Results and Recommendations: _____
_____
_____
*Please provide us with a copy of the Evaluation Report.

Type of Evaluation Completed: _____
Date of most recent test: _____ Where tested: _____ By Whom? _____ Test Results and Recommendations:
_____
_____
*Please provide us with a copy of the Evaluation Report.

Does your child have a current IEP? ___Yes ___ No If yes, please send a copy to this clinic.

What goals have been targeted in your child's IEP?
What progress have you observed?
What factors do you think have contributed to progress / lack of progress?

Do you have the opportunity to observe your child's therapy sessions?

Do you receive “homework” to practice with your child?
If so, describe the practice sessions.