the emerge CENTER
for communication, behavior, and development

Case History

Name: _____Date: _____

Concern/Reason for Visit: _____

Who referred you to our clinic? _____

School/Employer: _____

Primary Care Physician/Pediatrician:_____

AUDIOLOGY *Please circle all that apply:*

Ear infection/s (how many)_____	Meningitis	Chemotherapy
Tubes	Allergies	In utero infection (CMV, Rubella)
Medication/Drugs during Pregnancy		Problems during pregnancy/childbirth
Ventilation of ECMO use	Pain/Pulling ear	Ear/head trauma
Dizziness (describe): _____		Neurodegenetive Disorder
Ringing in ears	Red ears	Fluctuating hearing loss
Exposure to loud noise	Drainage	Sudden hearing loss

Other_____
Hospitalizations? Surgeries? _____
Current medical condition: Poor Fair Good Excellent
List medications: _____
_____
Do you wear Hearing Aids? Yes No
Is there a family history of hearing loss? Yes No
Passed newborn hearing screening? Yes No

SPEECH

Please give **age of development** (year and month) for these **speech and motor** milestones:
Making speech sounds (babbling) _____ First words _____
Using 2-3 word phrases_____ Walked at (age) _____

How many words are in the child's vocabulary? _____ Balance normal? Yes No
Have ear infections been frequent? Yes No Are P.E. tubes present? Yes No
Has child ever been evaluated for speech/language delay? Yes No
Is the child currently receiving speech therapy? Yes No
Has the child received speech therapy in the past? Yes No
Where? _____
Does child respond when his/her name is called? Yes No
Does the child understand most of what you say? Yes No
Does child give good eye contact? Yes No Does child point? Yes No
Does child look when you point? Yes No
Does child imitate words you say? Yes No
Does child have siblings? Yes No Ages? _____
Is there a family history of speech/language delay? Yes No
Does the family have any spiritual, cultural, or religious beliefs that influence the child:
Yes No

OCCUPATIONAL THERAPY *Please check all that apply:*

Please give **age of development** (year and month) for these **motor** milestones:

Sat upright _____ Crawled _____ Walked at (age) _____

Fed self _____ Fork/Spoon _____ Drink open cup _____

Dresses self _____ Toilet trained _____

Balance normal? __ Yes __ No

Has child ever been evaluated for fine motor, oral motor, self-help or sensory motor delay?
__ Yes __ No

Is the child currently receiving occupational therapy? __ Yes __ No

Has the child received occupational therapy in the past? __ Yes __ No

Where? _____

Any other comments? Please write below.