Calvin Speech Pathology and Audiology

Calvin Speech & Hearing Clinic
On the campus of Calvin University
3201 Burton SE, Grand Rapids, MI 49546
spaud@calvin.edu 616-526-6070 | f. 616-469-1355

Pediatric Case History

We appreciate your commitment to attend all sessions. Successful treatment depends upon a weekly commitment, and students spend many hours in preparation for each client's sessions. Absence of three or more sessions (2 or more in summer) may result in losing your time slot.

Patient & Family Information

Date of Application:	Clinic program or session applying for:			Virtual Therapy: Yes No Either
Patient Name: **Last** **First** **MI**		DOB:	Age:	Gender: □ Male □ Female
Parent(s)/Guardian Name:	**Child lives with (check one):** □ Birth Parents □ Foster Parents □ One Parent □ Adoptive Parents □ Parent and Step-Parent □ Other:			
Address:				
City:	State:	Zip:		
Home Phone:	Cell Phone:	Work Phone:	Which # preferred:	
Email Address:	Receive Documents Securely by Email: □ Yes □ No			
Health Insurance Name: □ we do not have health insurance	How did you hear about us?			

Other Children in the Family:

Name:	Age:	Gender:	Grade:	Any speech-hearing problems?
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Other Languages in the home:

Is there a language other than English spoke in the home? □ No (skip to next section) □ Yes (which one?):	
Does the child speak the language? □ Yes □ No	Who in the home speaks the language?
Does the child understand the language? □ Yes □ No	Which language is the child's preferred language?

Other Needs:

Are there any cultural norms that you would like us to know about that may affect delivery of services for your child? □ No □ Yes (explain):
Are there any religious or spiritual needs that would be helpful to know that may affect delivery of services for your child? □ No □ Yes (explain):

Birth History

Was there anything unusual about the pregnancy or birth? □ No □ Yes (explain):	
How many weeks was the pregnancy?	How old was the mother when the child was born?
Did the mother have any health problems during pregnancy? □ No □ Yes (explain):	
After the birth, did the baby require additional hospital stay? □ No □ Yes (how long): _____ Explain:	

General Medical History

Primary Care Doctor:	Phone Number:
Other Specialists:	
Are Immunizations up to date? □ Yes □ No	Please list any medications your child takes regularly:

Has your child had any of the following?

□ adenoidectomy	□ feeding troubles	□ sinusitis	□ allergies; Type? _____
□ flu	□ sleeping difficulties	□ breathing difficulties	
□ head injury	□ stomach/bowel trouble	□ chicken pox	
□ heart trouble	□ thumb/finger sucking	□ colds	□ frequent fevers
□ tonsillectomy	□ meningitis	□ ear infections; How often? _____	
□ tonsillitis	□ ear tubes	□ scarlet fever	
□ vision problems	□ encephalitis	□ seizures	□ other: _____

Any other accidents or injuries?
Is your child currently (or recently) under a physician's care? □ No □ Yes (explain):

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

sat alone	babbled	said first words	put two words together
spoke in short sentences	walked	toilet trained	grasped crayon/pencil

Please check which words describe your child:

□ affectionate	□ demanding	□ playful	□ overactive	□ calm
□ good disposition	□ shy	□ angry	□ stubborn	□ sad
□ curious	□ hard to comfort	□ likes people	□ confident	□ fearful
□ joyful	□ fearless	□ other:		

Do you have any concerns about your child's (please check which apply):

Height	□ yes	□ no	□ not sure	Vision	□ yes	□ no	□ not sure
Weight	□ yes	□ no	□ not sure	Head Size	□ yes	□ no	□ not sure
Hearing	□ yes	□ no	□ not sure	Movement	□ yes	□ no	□ not sure
Behavior	□ yes	□ no	□ not sure	Speech/Language	□ yes	□ no	□ not sure
Eating	□ yes	□ no	□ not sure	Nutrition	□ yes	□ no	□ not sure
Sleeping	□ yes	□ no	□ not sure	Sensory Processing	□ yes	□ no	□ not sure

Sensory:

Does your child have any strong preferences and/or consume limited food consistencies? □ Yes □ No	
Does your child crash, bump, jump, or seek physical activities outside what appear typical? □ Yes □ No	
Does your child wear limited clothing textures? □ Yes □ No	Does your child have sensitivities to lights, sounds, or strong smells? □ Yes □ No

Speech & Hearing History

Do you feel your child has a speech problem? □ Yes □ No

Please check areas of concern for speech/language:

□ articulation (speech sounds)	□ apraxia/motor speech	□ speaks in short sentences/phrases
□ understanding of language (auditory comprehension)		□ social skills/pragmatics
□ expressive language/vocabulary	□ stuttering (fluency)	□ use of a communication device (AAC)
□ voice disorder	□ dysphagia (swallowing)	□ hearing impairment/cochlear implant
□ traumatic brain injury (attention/cognition/memory/organization)		

Has your child ever had a speech evaluation/screening? □ Yes □ No
If yes, where and when?
What were you told?
Has your child ever had speech therapy? □ Yes □ No
If yes, where and when?

What were they working on?
Is your child receiving speech support through the school system? □ Yes □ No School District and Type:
Do you feel your child has a hearing problem? □ No □ Yes, please describe:
Has your child ever had a hearing evaluation/screening? □ No □ Yes
If yes, where and when?
What were the results?
Has your child ever received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, ear, nose, throat doctor)? □ No □ Yes
If yes, please describe:
Is your child aware of, or frustrated by, any speech-language difficulties?
What do you see as your child's most difficult problem in the home?
What do you see as your child's most difficult problem in school?
What are some questions you would like answered?

*** Please send or bring any Speech-Language evaluations, OT/PT evals, IFSP/IEPs, or any other documents that would help us evaluate and plan for your child.**

Current Speech-Language-Hearing

Does your child…

Repeat sounds, words, or phrases over and over?	□ yes	□ no
Follow simple directions ("shut the door, "get your shoes")?	□ yes	□ no
Understand what you are saying?	□ yes	□ no
Respond correctly to yes/no questions?	□ yes	□ no
Retrieve/point to common objects upon request (ball, cup, shoe)?	□ yes	□ no
Respond correctly to who/what/where/when/why questions?	□ yes	□ no
Sleeping	□ yes	□ no

Does your child communicate using…

□ body language	□ Sounds (vowels, grunting)	□ words (shoe, doggy)	□ 2 to 4 word sentences
□ sentences longer than four words		□ other:	

Behavioral characteristics:

□ cooperative	□ restless	□ attentive	□ poor eye contact	□ willing to try new activities
□ separation difficulties	□ withdrawn	□ easily distracted/short attention		□ inappropriate behavior
□ easily frustrated/impulsive	□ stubborn	□ self-abusive behavior		

School History

If your child is in school, please answer the following:

Name of School	Grade in School
What are your child's strengths and/or best subjects?	
Is your child having difficulty with any subjects?	
Is your child receiving help in any subjects?	

Additional Comments:

Submit Form:

Mail: Calvin Speech & Hearing Clinic,
Calvin University
3201 Burton St SE
Grand Rapids, MI 49546

Fax: 616-469-1355 By email: spaud@calvin.edu Clinic phone: 616-526-6070

For driving directions to our clinic (DeVos Communication Center, 2nd floor lobby): http://www.calvin.edu/map/

For more information about our clinic: www.calvin.edu/go/SpeechClinic

My child is available on the following days (please check all that apply; add any scheduling details that would be helpful):

Monday (9a-12p) _____ Tuesday (1-6p) _____ Wednesday (9a-12p) _____ Thursday (1-5p) _____

Scheduling Comments:

Pediatric sessions are on Monday and Wednesday mornings. Afternoon sessions are available on a limited basis.