PATIENT NAME:_____ **D.O.B.:**_____

SUMMIT SPEECH SCHOOL
AUDIOLOGY CASE HISTORY

CONFIDENTIAL

Date: _____ Referred by: _____

FAMILY INFORMATION

Mother's Name: _____

Father's Name: _____

Home Phone:_____ Other Phone:_____

Address: _____
(street)

_____ _____ _____ _____
(city) *(state)* *(zip code)* *(county)*

Name Child Uses:_____ *(Circle one)* Male Female

Pediatrician:_____

Address: _____

_____

Phone: _____

OCCUPATION AND EMPLOYER INFORMATION

Mother:_____

Father:_____

Significant family history for developmental, speech/language, learning delays and/or hearing loss:

_____

_____

_____

Extended family and siblings:

Name	D.O.B.	Developmental Concerns
_____	_____	_____
_____	_____	_____

BIRTH HISTORY

Any illnesses or complications during pregnancy? _____

_____

Length of pregnancy _____ Birth weight _____

Complications at birth? _____

_____

Jaundice? _____ If so, how treated? _____

NICU? _____ Length of hospitalization _____

MEDICAL HISTORY

History of:

Allergies _____ High fevers _____

Asthma _____ I/V antibiotics _____

Ear infections _____ Seizures _____

Frequent colds _____ Tonsillitis _____

Head injury _____ Sinus infections _____

P.E. tubes _____

Audiological Evaluations: _____

_____

_____

Speech/Language Evaluations: _____

_____

_____

Serious illnesses, injuries, hospitalizations: _____

_____

_____

Other Physicians Specialty Status

_____

_____

_____

Other Evaluations/Treatment Programs:

DEVELOPMENTAL HISTORY

Milestone comments: sitting/walking? Babbling / first words / phrases / sentences?

General Disposition: _____

Behavioral Concerns: _____

Favorite toys, activities: _____

Do you have concerns about your child's hearing? Explain _____

Does your child:

Respond to sounds when he/she cannot see the source of the sound? _____

Turn up the volume on the TV or radio? _____

React negatively to loud sounds? _____

Does your child wear hearing aids? _____

If so, what kind? _____

Does your child use an FM system? _____

SCHOOL INFORMATION

What school does your child attend? _____

Grade: _____

Does your child receive any special services at school (resource room, speech therapy, OT, PT, etc)? _____

If so, what kind and how often? _____

Does your child receive any special services privately? _____

_____

ADDITIONAL COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I give permission for my child _____ to receive an Audiological Evaluation at the Summit Speech School.

As parent/guardian I have provided the information included in this Audiology Case History.

_____ _____

Signature *(Parent/Guardian)* Signature *(Audiology Department)*

SUMMIT SPEECH SCHOOL

Main Office
705 Central Avenue
New Providence, NJ 07974
(908) 508-0011
Fax: (908) 508-0012

South at Mansfield Township Elementary School
200 Mansfield Road East
Columbus, NJ 08022
609-298-2037

AUTHORIZATION TO OBTAIN AND RELEASE RECORDS

I hereby authorize the release to and from the Summit Speech School of all Audiological, Educational, Behavioral, and/or Speech/Language information, verbally or in writing, pertaining to:

_____ _____
(Child's Name) (D.O.B.)

This authorization shall remain in effect for the period the student is enrolled in Summit Speech School programs, unless I revoke it in writing.

Please list the full address of agencies that will be permitted to share information, as a result of this release:

Audiological: _____
_____
_____

Educational: _____
(Nursery Schools, etc.) _____
_____

Medical: _____
(Doctors, Therapists) _____
_____

Psychological: _____
_____
_____

Speech/Language: _____
(Private Therapist) _____
_____

Other: _____
_____
_____

_____ _____ _____
Signature of Parent or Legal Guardian Print Name of Parent or Legal Guardian Date