PROFESSIONAL
HEARING CENTER
A Division of Ascentist Physicians Group LLC

CASE HISTORY - CHILD

Identifying Information

Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Age_____ Birthdate_____/_____/_____ Gender M F Email_____

Home Phone_____ Other Phone_____

Address correspondence to (please check all that apply) ☐mother ☐father ☐other_____

Person completing form_____ Relation to child_____

Father's name_____ Occupation_____

Work Phone_____ Fax_____

Mother's Name_____ Occupation_____

Work Phone_____ Fax_____

Child's School_____ Grade_____

Who referred child?_____

Reason:_____

Background Information

Reason for testing (please check all that apply):

☐Academic ☐Attention

☐Speech-Language ☐Emotional

☐Hearing ☐Other_____

What would you like to get from this evaluation?_____

_____

_____

Other Children in Family:

Name	Age	Gend.	List any speech-language, learning problems
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____

Child's Health History

☐Allergies	☐Ear Infections/Fluid	☐Head Trauma
☐ADD/ADHD (circle which)	☐Dyslexia	☐Seizures
☐Asperger	☐Dizziness	☐Taking medication
☐Cerebral Palsy	☐Epilepsy	☐Other/s_____

Please provide information for ✓ed items above (e.g, when ear prob started, how often, when ear tubes):

_____

_____

_____

Developmental History

If developmental milestones were delayed, please check box. If so, at what age acquired?

☐Babbling_____ ☐Saying sentences_____

☐Saying words_____ ☐Walking_____

Further information about any developmental problems_____

_____

_____

_____

Other Evaluations

Child seen for Speech-Language, Learning, Hearing, Vision, Psychological, OT, or Educational?

☐None If yes, please explain who was seen, when, why and what was found.

Who_____ Profession_____ When_____

Why_____ What was found_____

Who_____ Profession_____ When_____

Why_____ What was found_____

Who_____ Profession_____ When_____

Why_____ What was found_____

Other diagnosis /educational therapy/training?_____

_____

Social and Emotional Information

Please check whether or not your child has had these traits:

Trait	yes	no		Trait	yes	no
Anxiety, tension				Lacks motivation		
Appears confused in noisy places				Lacks self-confidence		
Awkward, clumsy				Maintaining proper sequence/order		
Dislikes school				Mixes up speech sounds		
Disobedient				Needs quiet to study		
Disruptive				Often says “huh” or “what” a lot		
Does not complete assignments				Over-reacts emotionally		
Does not express emotion				Preference play with younger kids		
Does opposite of what is requested				Preference for solitary activities		
Easily distracted				Problems with the law		
Easily flustered or confused				Restless, problems sitting still		
Easily frustrated				Sensitivity to loud sounds		
Easily upset by new situations				Short attention span		
Excessive talking				Short-term memory problem		
Fakes illness				Shy		
Forgetful				Temper tantrums		
Generally appears sad				Tires easily		
Had psychological counseling				Trouble following oral directions		
Hyperactive				Trouble telling where sounds are		
Impulsive				Trouble understanding television		
Inappropriate social behavior				Uncooperative		

D4		N3		M2		OFFICE USE	L1		O1		C1		P2	

Educational History

Child’s preferred hand for writing ☐right ☐left ☐ambidextrous

Has child repeated a grade? ☐yes ☐no If yes, what grade? ___ Why?_____
Is child:
In open classroom (more than one class with just partitions) ☐yes ☐no
Traditional classroom ☐yes ☐no
Receiving special help ☐yes ☐no If yes, what?_____

Having problems now or in past/extra help with:
Reading: a) comprehension ☐yes ☐no b) accuracy/oral reading ☐yes ☐no
Phonics (now or in the past) ☐yes ☐no ☐ not applicable (why?)_____
Spelling ☐yes ☐no If yes, is it very severe? ☐yes ☐no

Math: a) facts ☐yes ☐no b) reading math problems ☐yes ☐no
Foreign language ☐yes ☐no ☐not applicable (why?)_____
Handwriting ☐yes ☐no If yes, is it very severe? ☐yes ☐no

Other comments:_____
_____

Does child seem to rely on vision at school? ☐yes ☐no
Any relatives have problems in school? ☐yes ☐ no
If yes, who and problem:_____

THANK YOU FOR YOUR ASSISTANCE BY COMPLETING THIS QUESTIONNAIRE

BUFFALO MODEL QUESTIONNAIRE-REVISED

Name _____ **Date** _____

Age _____ **Grade** _____ **Form completed by** _____

Please circle 'Y' if your child is currently receiving or has received any of the services and indicate the number of years received:

Y Auditory training? ___ yrs	Y Speech therapy? ___ yrs	Y Phonological awareness training? ___ yrs
Y Special phonics training? ___ yrs	Y Reading therapy/tutoring? ___ yrs	Y Sensory-integration training? ___ yrs

1) Please circle 'Y' if this *may be a problem* or 'N' if *not a problem*
2) If it does not apply, circle 'NA' (e.g., if a kindergartner has no foreign language training; circle 'NA' for #8)

DEC				
1)	Y	N	NA	Speech (saying sounds)
2)	Y	N	NA	Understand language
3)	Y	N	NA	Understand verbal directions
4)	Y	N	NA	Oral Reading Accuracy
5)	Y	N	NA	Phonics
6)	Y	N	NA	Spelling
7)	Y	N	NA	Responds slowly/delayed
8)	Y	N	NA	Foreign language learning
9)	Y	N	NA	Speaks slowly
Noi				
10)	Y	N	NA	Hypersensitive to sounds
11)	Y	N	NA	Distracted by sounds
12)	Y	N	NA	Understand speech in noise
13)	Y	N	NA	Noisy child/makes noises
Mem				
14)	Y	N	NA	Responds quickly
15)	Y	N	NA	Frequently interrupts others
16)	Y	N	NA	Reading Comprehension
17)	Y	N	NA	Speaks quickly
18)	Y	N	NA	Forgets things told
19)	Y	N	NA	Forgets oral directions
Var				
20)	Y	N	NA	Attention
21)	Y	N	NA	Using language
22)	Y	N	NA	ADHD/ADD
23)	Y	N	NA	Anxiety (e.g. new situations)

INT				
24)	Y	N	NA	Very poor handwriting
25)	Y	N	NA	Easily associates sounds & letters
26)	Y	N	NA	Severe reading/spelling
27)	Y	N	NA	Severe visual perception
28)	Y	N	NA	Sometimes very long delays
29)	Y	N	NA	Dyslexia
ORG				
30)	Y	N	NA	Belongings are disorganized
31)	Y	N	NA	Sequence verbal items correctly
32)	Y	N	NA	Messy/tends to lose things
APD				
33)	Y	N	NA	Ear infections/ ear fluid as child
34)	Y	N	NA	Processing what is heard
35)	Y	N	NA	Learning problems (LD)
36)	Y	N	NA	Following verbal directions
37)	Y	N	NA	Intellectually challenged
38)	Y	N	NA	Head injury
39)	Y	N	NA	Autism or related problem
Gen				
40)	Y	N	NA	Hypersensitive to touch
41)	Y	N	NA	Eye contact with speaker
42)	Y	N	NA	Long-term memory
43)	Y	N	NA	Psychological
44)	Y	N	NA	Behavior
45)	Y	N	NA	Coordination
46)	Y	N	NA	Allergies
47)	Y	N	NA	Math
48)	Y	N	NA	Hearing

Comments, explanations, questions: _____

_____

For Office Use Only

DEC	(Noi)	(Mem)	(Var)	TFM	INT	ORG	APD	ΣCAP	(Gen)
/9	(/4)	(/6)	(/4)	/14	/6	/3	/7	/39	(/9)