**UNIVERSITY SPEECH, LANGUAGE AND HEARING CLINIC**
***A UNITED WAY FACILITY***
100 Clinical Research Center
HOUSTON, TEXAS 77204-6018
(713) 743-0915

Please provide, to the best of your ability, the following information about your child. If a question is not applicable to your child, place an NA in the space provided. If you need more space to answer a particular question, you may wish to attach a separate sheet.

## VOICE CASE HISTORY FORM – CHILD AND TEEN

Name _____ Birthdate _____ Male of Female (Circle One)

Address _____ City _____ , State _____ Zip _____

Parent's Names _____

Home Phone _____ Mother's Work Phone _____ Father's Work Phone _____

Informant _____ Relationship to the client _____

Referred by _____ ____ Relationship _____ _____

School _____ Grade _____ Teacher _____

Name of Family Physician _____

Address _____ City _____ , State _____ Zip _____

**Have you been examined by an Ear, Nose and Throat Physician?___ If so when?** _____

Name of E.N.T. Physician _____

Address _____ City _____ , State _____ Zip _____

**DESCRIBE THE CHILD'S VOICE PROBLEM:** _____

_____

_____

_____

## ORIGIN AND DEVELOPMENT OF VOICE PROBLEM:

Describe the circumstances under which the voice problem was first noticed _____

_____

Suddenly developed? _____ Gradually developed? _____

Duration of problem? _____ Who first noticed the problem? _____

Check below if your child had done any of the following before noticing the problem:

Shouting (___) Screaming (___) Extensive speaking (___)

Singing ( ) Dramatics ( ) Has the child been trained in either of these areas? _____

If so, which? _____

Had your child had an illness or surgery about the time of onset? _____ If so, please describe: _____

_____

_____

Has your child seen a laryngologist? _____ If so, state name and address provided in section 1.

## HISTORY OF VOICE PROBLEM

What do you think caused the voice problem? _____

_____

What is your opinion on the sound of your child's voice? _____

What is the child's attitude towards his/her voice? _____

How do family, friends, teachers and others regard the child's voice? _____

_____

What is your reason for seeking help? _____

## HISTORY OF VOCAL USE

Has your child ever done any of the following: excessive crying ( ) screaming ( ) yelling ( )

If so, did a hernia result from this? _____ Was there abnormality in breathing? _____

Noisy breathing? _____

Is he/she excessively talkative? _____ Vocally noisy? ( i.e., imitating noises of planes, trains, etc.) _____

Check whether your child's voice is better or worse in these situations:

Consider each of the following items and check whether your voice is better or worse in these situations:

| Time/Condition | Better | Worse | | |
|---|---|---|---|---|
| In the morning | ( ) | ( ) | | |
| In the afternoon | ( ) | ( ) | | |
| In the evening | ( ) | ( ) | | |
| At school | ( ) | ( ) | | |
| At home | ( ) | ( ) | | |
| When you are tired | ( ) | ( ) | | |
| When you are happy | ( ) | ( ) | | |
| When you are depressed | ( ) | ( ) | | |
| In different seasons | ( ) | ( ) | | When? |
| During weather changes | ( ) | ( ) | | When? |
| In certain places | ( ) | ( ) | | Where? |
| With certain people | ( ) | ( ) | | |

Other (please explain) _____

## SPEECH DEVELOPMENT

Did the child make sounds during infancy? _____ At approximately what age? _____

With or without you talking to him/er? _____ Age of first words:_____

Age at which child put two words together (Ex. "Want cookie.") _____

Age at which child put three words together? (Ex. "Mommy go bye-bye.") _____

Did the child talk little or much? _____

Describe:_____

Any periods when the child quit talking? _____Describe:_____

_____

Does the child have any trouble pronouncing words? _____ Does the child have difficulty understanding what is said? _____

Does the child have difficulty expressing her/himself verbally? _____

If yes, describe: _____

Has there been previous speech/language testing? _____ If yes, by whom? _____

When?_____ Where? _____

Results: _____

Has there been previous speech/language therapy? _____ If yes, by whom? _____

When? _____ Where? _____

Results: _____

Has any effort been made at home to correct the problem? _____ If yes, by whom:_____

_____

What methods were used to correct the problem? _____

Have there been any relatives with speech/language problems? _____ If yes, please state relationship(s) and the problem(s): _____

## BIRTH HISTORY

What was the health of the mother during pregnancy? _____

Any: Measles? ( ) Falls? ( ) Drugs Taken? ( ) _____

Alcohol? ( ) Rh Negative? ( ) Number of previous pregnancies: _____

Number of living children: _____ Length of pregnancy with this child? _____

Doctor who delivered this child? _____

Delivery: Difficult? ( ) Easy? ( ) Injury? ( ) _____ Length of labor: _____

Breech Birth? ( ) C-Section? ( ) APGAR score? _____

Name of child's pediatrician: _____

Pediatricians address: _____

Infant's Status: Birth weight? _____ Birth Length? _____ Shape of Head? _____

_____ Jaundiced? ( ) ___ Breast fed? ( ) _____ Colic? ( )

_____ Feeding problems? _____

## MOTOR DEVELOPMENT

Age of holding head up? _____ Age of sitting up? _____

How did the child crawl (hands on knees? Stomach? Forward? Backward?) Describe: _____

_____

Age of first steps alone: _____ Describe Coordination: _____

Which hand does the child use to: Write? _____ Throw a ball? _____ Eat? _____ Use tools? _____

Has child shifted from one hand to the other? _____

Any relatives left-handed? _____ If yes, list and state relationships: _____

_____

## MEDICAL HISTORY

Are there any serious medical problems? _____ If so, list: _____

_____

Has there been vision testing? _____ If so by whom? _____

Is vision normal? _____ Are glasses worn? _____ If yes, how long since last examination? _____

State the vision problem: _____

At what age were glasses first prescribed? _____

Any tendencies to print letters or numerals backwards? _____ If so, which one? _____

Any tendencies to read words or numerals backwards? _____ Is paperwork neat? _____

Has there been hearing testing? _____ If so, by whom? _____ Where? _____

Results? _____

When was the last hearing examination? _____ Was hearing normal? _____

If no, state the problem: _____

Are hearing aids worn? _____Right? _____ Left?_____Type?_____

Any earaches and/or infections?_____ If yes, was medical treatment necessary? _____

Age(s) at which child experienced ear problem? _____ Date of last infection? _____

What medication, if any was prescribed? _____

Were Pressure Equalizers (PE) tubes inserted? _____ If so, what date?_____

To your knowledge, are the tubes still in place?_____

Has the child experienced seizures?_____If yes, when?_____

Have medications been prescribed?_____If so, list:_____

Any fainting spells?_____If so, when?_____

Any other pertinent medical information, (such as accidents, operations, allergies, etc.)_____

Age of bladder control during the day_____During the night_____

Time child goes to bed?_____Time child gets up?_____Any problems sleeping?_____

_____

Check diseases and/or condition your child has had and state age of occurrence. Indicate any that affected voice with an asterisk (*)

Measles ( ) _____ _____ Mumps( ) _____
Chicken Pox ( ) _____ _____ Whooping Cough( ) _____
Diphtheria ( ) _____ _____ Rheumatic Fever( ) _____
Poliomyelitis( ) _____ _____ Scarlet Fever( ) _____
Mononucleosis ( ) _____ _____ Cancer( ) _____
Pneumonia ( ) _____ _____ Anemia( ) _____
Hear Disease ( ) _____ Glandular Disturbances( ) _____
Asthma ( ) _____ _____ Post Nasal Drip( ) _____
Tinnitus-ringing in the ear ( ) _____ _____ Mouth Breather( ) _____
Retarded Sexual Development ( ) _____ _____ Allergies( ) _____
Chronic Sinus Attacks ( ) _____ _____ Thyroid Problems( ) _____
Chronic Cough ( ) _____ _____ Chronically tired( ) _____
Nasal Congestion ( ) _____ _____ Dry Skin and/or Hair( ) _____
Numbness ( ) _____ _____ Dizziness( ) _____
Dryness in nose and/or mouth ( ) _____ _____ Sluggishness ( ) _____
Nervousness ( ) _____ _____ Average temperature below normal ( ) _____
Difficulty Swallowing ( ) _____ _____ Strained throat ( ) _____
Chilled when others are warm ( ) _____ _____ Body Aches ( ) _____
Others: _____

What injuries has the child had (especially in the neck or throat areas)? _____

_____

At what age did these injuries occur? _____

Indicate if your child has had any of the following surgeries. State age and results of surgery: _____

Tonsils and adenoids: _____

List medications the child is taking, the reason for taking them and how long the child has been taking each one: _____

What drugs has the child taken over an extended period of time in the past? _____

Does the child take vitamins? _____ What type? _____

What medications were you taking when your voice problem first appeared? _____

Does the child have pain or sensations of presence in the throat or larynx? _____

Has water ever gone up the child's nose? _____

Has the child ever put anything up their nose or swallowed anything unusual? _____

Does the child have a history of laryngeal pathology: Growths? _____ obstructions? _____

Inflammation? _____ Tickling? _____ Describe: _____

## SCHOOL HISTORY

Are there any problems in school? _____

If yes, check problem areas:

Understanding what is said ( ) Expressing self orally ( ) Reading ( ) Writing ( )

Spelling ( ) Arithmetic ( ) Paying attention ( ) Memory ( ) Athletics ( )

Getting along with peers ( ) _____Other problems?_____

Type of Class: Regular education? _____ Special Education? _____

If Special Education, what label was used to qualify child? (Ex. Learning disabled)_ _____

Have teachers noticed problems? ____ ____ If yes, what was indicated? _____

Current grades: _____ Estimate child's reading level: _____

Any resource help? _____ Private tutoring? _____

Has school performance changed over the years? _____ If yes, how? _____

Has the child repeated a grade? _____ If yes, which grade? _____ Why? _____

What are the child's best subjects?_____

Worst subjects?_____

Does the child have problems working independently? _____Do other members of his family have learning problems? _____ If yes, state relationship and problem:_____

_____

## SOCIAL AND HOME ENVIRONMENT

**Parents:** Age of mother:_____ Education (highest level) _____ Present occupation _____

Age of father:_____ Education (highest level) Present occupation_____

Divorced? _____When?_____Separated? _____ When? _____

Step or foster parents? _____

Siblings: Brothers: Ages _____ Any problems? _____

Sisters: Ages_____ Any problems? _____

Are there any other persons living in the home? _____ Please describe age and relationship of other persons_____

Does your child have friends? Many? ( ) A few? ( ) Very few? ( )

Does your child mostly socialize with children: How own age? ( ) Younger?( ) Older? ( )

What is the child's attitude toward the speech problem? _____

_____

What is the attitude of the family, friends, and relatives towards the child's speech problems? _____

_____

_____

## ADDITIONAL QUESTIONS OR COMMENTS:

_____

_____

_____

_____

_____

_____

**Return this completed form as promptly as possible. Only after the form has been received in this office will we contact you to set up the evaluation you have requested.**