ECKELMANN-TAYLOR
SPEECH AND HEARING CLINIC
Illinois State University

AAC Child Case History Form

Name ______________________________ Date ______________

Date of Birth ______________ Age __________ Pronouns ______________________

School ______________ Grade __________

Native Language ______________________ Primary Language ______________________

______________________________ ______________________________

Mother's Name ______________________ Address ______________________

Phone ______________________ Alternate Phone ______________________

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email Address ______________________

______________________________ ______________________________

Father's Name ______________________ Address (if different) ______________________

Phone ______________________ Alternate Phone ______________________

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email Address ______________________

______________________________ ______________________________

Person Completing Form ______________________________

Physician's Name ______________________ Phone ______________________

Referred By ______________________________

Insurance:

Primary ______________________ Secondary ______________________

Policy # ______________________ Policy # ______________________

Group # ______________________ Group # ______________________

Subscriber Name ______________________ Subscriber Name ______________________

Subscriber Phone Number & Address ______________________________

Subscriber DOB ______________________ Subscriber DOB ______________________

DISABILITY INFORMATION

1. What is the child's primary disability?

____

____

2. Are there any secondary disabilities?

____

____

PRENATAL AND BIRTH HISTORY

1. What was the mother's general health during pregnancy (illness, accidents, medications, etc.)?

____

____

2. Was the child born prematurely? If so, how many weeks early?

____

____

3. Were there any complications with labor?

____

____

4. What was the child's birth weight?

____

5. Was the child blue or jaundiced?

____

6. What number was this child in order of pregnancies?

____

7. When did he/she sit up unassisted? Walk? Feed himself/herself?

____

MEDICAL HISTORY

1. Please check your child's diagnosis, if applicable:
   - ☐ Cerebral Palsy
   - ☐ Down's Syndrome
   - ☐ Unknown
   - ☐ Feeding/swallow difficulties
   - ☐ Traumatic Brain Injury
   - ☐ Neurological Disease, please specify ______________________________

2. Please indicate if, and at what age(s), the child experienced the following illnesses and conditions:
   - ☐ Allergies ______________________________
   - ☐ Chicken Pox ______________________________
   - ☐ Ear Infection ______________________________
   - ☐ Measles ______________________________
   - ☐ Influenza ______________________________
   - ☐ Mumps ______________________________
   - ☐ Seizures ______________________________
   - ☐ Asthma ______________________________
   - ☐ Croup ______________________________
   - ☐ Encephalitis ______________________________
   - ☐ High Fever ______________________________
   - ☐ Meningitis ______________________________
   - ☐ Pneumonia ______________________________
   - ☐ Tonsillitis ______________________________
   - ☐ Other ______________________________

3. Has the child had any surgeries? If yes, what type and when?

____

4. Describe any major accidents or hospitalizations.

____

5. Is the child taking any medications? If yes, please list the names.

____

CURRENT STATUS

Communication Status

1. Briefly describe the child's intelligibility (how well he/she is understood).

   To you ____

   To members of your family ____

   To others ____

2. What are your present concerns about the child's communication?

____

____

3. How does the child react to his/her communication difficulties?

____

____

4. How would you like to communicate with the child in the future?

____

____

5. Has the child used any assistive devices? If yes, please describe.

____

____

6. Is the child currently using a device? If yes, please describe.

____

____

7. Please indicate behaviors the child exhibits:

   ☐ Facial expressions
   ☐ Eye gaze
   ☐ Vocalization (i.e lauging, crying)
   ☐ Nonconventional behavior
   ☐ Gestures (i.e. pointing)
   ☐ Meaningful vocalizations
   ☐ Uses manual signs
   ☐ Can read (at what grade level?) ___________________
   ☐ Can write (at what grade level?) __________________

9. Please indicate whether the child demonstrates these behaviors:

   ☐ Attends to speaker or listener
   ☐ Initiates a greeting
   ☐ Takes turns during conversation
   ☐ Introduces new topics
   ☐ Responds to questions
   ☐ Requests help if message is not understood
   ☐ Responds to jokes
   ☐ Tells jokes
   ☐ Understands teasing
   ☐ Understands hints
   ☐ Tries to makes self understood even if message is not understood the first time If yes, please describe e.g., repeating, pointing, etc.) ____

   ☐ Uses sign language
   ☐ Uses single words
   ☐ 1-10 words
   ☐ 11-20 words
   ☐ 21-30 words
   ☐ More than 30 words
   ☐ Uses phrases/sentences

Vision

1. Please check appropriate box:
   ☐ Child has no visual impairment
   ☐ Child has visual impairment (if so, please describe) ____________________

Hearing

1. Please check appropriate box:
   ☐ Child has no hearing loss
   ☐ Child has mild hearing loss
   ☐ Child has moderate hearing loss
   ☐ Child has severe hearing loss
   ☐ Child is deaf

Motor

1. Please check appropriate box:
   ☐ Child has no motor impairment
   ☐ Child has motor impairment (If yes, please describe impairment.) ____________________
2. Is the child ambulatory? If he/she requires adaptive equipment, please specify any special equipment used for mobility process.

____

____

Other Sensory Information

1. Is the child over-or-under-sensitive to touch?

____

____

2. Is the child sensitive to specific textures or tastes? If yes, please explain.

____

____

3. Does the child get overstimulated by noise? Visual stimuli? Olfactory stimuli?

____

____

Cognition

1. Please check the child's level of:
   Alertness ☐ Very alert ☐ Somewhat alert ☐ Not very alert ☐ Rarely alert
   Attention span ☐ Long ☐ Average ☐ Short
2. Is the child able to express preferences and choices? ☐ Yes ☐ No
   If yes, how does he/she express this? (i.e. gesturing, crying) ____________________

   ____

PERSONAL/FAMILY INFORMATION

1. What are the child's hobbies, interests, favorite playthings?

____

____

2. Please list the people which the child regularly interacts with.

____

____

3. Is the child cared for outside of home/school? By whom? How long?

____

____

4. What is a typical daily schedule of activities for this child?

____

____

SUMMARY OF EVALUATIONS

Please indicate any evaluations the child has received and attach any reports indicating the results for:

1. Hearing
   - Date of most recent formal hearing test ____________________
   - Results ____________________
   - Audiologist name ____________________
   - Address ____________________
2. Motor
   - Date of most recent formal motor test ____________________
   - Physical therapist ____________________
   - Address ____________________
3. Vision
   - Date of most recent formal vision test ____________________
   - Results ____________________
   - Optometrist/Ophthalmologist ____________________
   - Address ____________________
4. Cognition
   - Date of most recent psychological test ____________________
   - Results ____________________
   - Psychologist ____________________
   - Address ____________________
5. Communication
   - Date of most recent speech/language test ____________________
   - Results ____________________
   - Speech-Language Pathologist ____________________
   - Address ____________________