SONARIS
EAR CENTER

# CHILD CASE HISTORY FORM

| | |
|---|---|
| Child's Name: | Date: |
| Date of Birth: | Sex: ☐ M ☐ F |

## HEARING

| | NO | YES |
|---|---|---|
| Are you concerned about your child's hearing? | ☐ | ☐ |
| Does your child ask for frequent repetition? | ☐ | ☐ |
| Does your child seem to mis-hear or seem to ignore you? | ☐ | ☐ |
| Does your child startle to loud noises? | ☐ | ☐ |
| Does your child respond when his/her name is called? | ☐ | ☐ |
| Did your child pass the newborn hearing screening? | ☐ | ☐ |

## SPEECH & LANGUAGE

| | NO | YES |
|---|---|---|
| Do you have concerns about your child's speech development?<br>If yes, please describe your concerns:<br>_____<br>_____ | ☐ | ☐ |

## EXPRESSIVE VERBAL LANGUAGE

| | NO | YES |
|---|---|---|
| Has your child been diagnosed with speech delay? | ☐ | ☐ |
| If your child is verbal, at what age did your (s)he say their first words? _____ | ☐ | ☐ |
| If your child is over 2 years old, is (s)he combining words and using simple 2 or 3 word phrases? | ☐ | ☐ |
| Is your child's speech easy to understand by people other than family members? | ☐ | ☐ |
| Has your child been assessed by a speech pathologist? | ☐ | ☐ |
| If your child is not talking yet, does (s)he try to use non-verbal gestures such as pointing to express their needs? | ☐ | ☐ |

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# CHILD CASE HISTORY FORM

| COMPREHENSION | | |
|---|---|---|
| | NO | YES |
| Does your child understand simple instructions? | ☐ | ☐ |
| Does your child have difficulty remembering instructions? | ☐ | ☐ |

| BEHAVIOURAL/SOCIAL | | |
|---|---|---|
| | NO | YES |
| Does your child enjoy playing games, singing and laughing with you? | ☐ | ☐ |
| Does your child display joint attention and make consistent and deliberate eye contact with you? | ☐ | ☐ |
| Does your child seek you for consolation when (s)he is hurt or upset? | ☐ | ☐ |
| Does your child show affection (i.e. likes to be hugged, kissed, tickled, smiles)? | ☐ | ☐ |
| Does your child show interest in other people? | ☐ | ☐ |
| Does your child enjoy playing with toys, story books and songs, etc.? | ☐ | ☐ |

| EDUCATION | | |
|---|---|---|
| | NO | YES |
| Do you or teachers/educators have concerns about your child's academic development?<br>If yes, please explain: _____ | ☐ | ☐ |
| Does your child have difficulty with reading, writing and spelling? | ☐ | ☐ |
| Does your child have difficulty following multi-step instructions? | ☐ | ☐ |
| Does your child have difficulty remembering verbal instructions? | ☐ | ☐ |
| Has your child ever had a psychoeducational assessment? | ☐ | ☐ |

| FAMILY HISTORY | | |
|---|---|---|
| | NO | YES |
| Does your child understand simple instructions? | ☐ | ☐ |
| Does your child have difficulty remembering instructions? | ☐ | ☐ |

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# CHILD CASE HISTORY FORM

## PREGNANCY & BIRTH

| | NO | YES |
|---|---|---|
| Did the mother use any street drugs, prescription medications (including antibiotics) or other chemical substances during pregnancy? If yes, specify: _____ | ☐ | ☐ |
| Did the mother consume alcohol during pregnancy? | ☐ | ☐ |
| Did the mother use tobacco or other nicotine containing substances? | ☐ | ☐ |
| Was the mother exposed to radiation / chemotherapy during pregnancy? | ☐ | ☐ |
| During pregnancy, was the mother diagnosed with:<br>☐ Syphilis ☐ Herpes ☐ Influenza ☐ HIV/AIDS ☐ Toxoplasmosis ☐ Other: _____ | | |
| Did the pregnancy proceed with to full term? If no, how many weeks early: _____ | ☐ | ☐ |
| Was labour included? If yes, please provide reason: _____ | ☐ | ☐ |
| Were there any complications during labour and delivery?<br>If yes, specify: _____ | ☐ | ☐ |

## NEONATAL HISTORY

| | NO | YES |
|---|---|---|
| What was your child's birth weight? _____ | | |
| Were the APGAR scores low at birth? | ☐ | ☐ |
| Did your child require oxygen after delivery?<br>If yes, for how long? _____ | ☐ | ☐ |
| Was your child admitted to intensive care? | ☐ | ☐ |
| Did your child require ECMO (extracorporeal membrane oxygenation)? | ☐ | ☐ |
| Was your child jaundiced?<br>If yes, was light therapy administered? ☐ Yes ☐ No | ☐ | ☐ |
| Does your child have defects of the ears and/or clefting of the lip and palate: | ☐ | ☐ |
| Was your child diagnosed with a syndrome?<br>If yes, for how long? _____ | ☐ | ☐ |
| Does your child have a heart defect? | ☐ | ☐ |

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# CHILD CASE HISTORY FORM

## INFANT/CHILDHOOD HISTORY

| | NO | YES |
|---|---|---|
| Has your child ever had a serious head injury? | ☐ | ☐ |

During pregnancy, was the mother diagnosed with: ☐ Mumps ☐ Measles ☐ Meningitis ☐ CMV

## EAR HEALTH HISTORY

Ear Infections: ☐ None ☐ Left ☐ Right ☐ Both

If any, specify what ages, how many, and how often:

_____

_____

If any, when was the last ear infection?

_____

_____

Ever had "tubes" in ears? ☐ None ☐ Left ☐ Right ☐ Both

If yes, specify when and how many times:

_____

_____

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