Today's Date:_________________ Study: __________________

Person Completing this form: _________________________ ID #: ____________

Case History Form (https://phonology.waisman.wisc.edu/)

Please complete the following information on your immediate family.

Participant Identification

Participant's Name: ____________________________________ DOB: ______________

Gender (please circle): *male/female*

Home Address: ____
Number Street City State Zip Code

Parent Identification

Mother's Name: ____________________________ DOB: ______________ Current Age: __________

Home Address: ____
Number Street City State Zip Code

Home Phone #: ______________________________ Occupation: ____________________________

Highest Level of Education*:* *Less than High School*☐ *High School Graduate*☐

High School + some college/tech school ☐ *College Graduate: B.A./B.S.*☐ *Master's* ☐ *Ph.D.*☐

Ethnicity: *Hispanic* ☐ *Non-Hispanic* ☐

Race: *American Indian/Alaska Native* ☐ *Asian* ☐ *Native Hawaiian/Pacific Islander* ☐

Black/African American ☐ *White* ☐ *More Than One Race* ☐

Father's Name: ____________________________ DOB: ______________ Current Age: __________

Home Address: ____
Number Street City State Zip Code

Home Phone #: ______________________________ Occupation: ____________________________

Highest Level of Education*:* *Less than High School*☐ *High School Graduate*☐

High School + some college/tech school ☐ *College Graduate: B.A./B.S.*☐ *Master's* ☐ *Ph.D.*☐

Ethnicity: *Hispanic* ☐ *Non-Hispanic* ☐

Race: *American Indian/Alaska Native* ☐ *Asian* ☐ *Native Hawaiian/Pacific Islander* ☐

Black/African American ☐ *White* ☐ *More Than One Race* ☐

Sibling Identification (Please list all children from oldest to youngest.)

Name: __________________________________ Gender (please circle): *male/female* Age: _______

Name: __________________________________ Gender (please circle): *male/female* Age: _______

Name: __________________________________ Gender (please circle): *male/female* Age: _______

Name: __________________________________ Gender (please circle): *male/female* Age: _______

Name: __________________________________ Gender (please circle): *male/female* Age: _______

Name: __________________________________ Gender (please circle): *male/female* Age: _______

Speech/Language History

Please indicate which speech/language disorder(s) this child has or had:

	Currently has	*Used to have*
Articulation/Phonological Disorder	☐	☐
Expressive Language Disorder	☐	☐
Receptive Language Disorder	☐	☐
Fluency Disorder (Stuttering)	☐	☐
Apraxia of Speech	☐	☐
Dysarthria	☐	☐
Aphasia	☐	☐
Voice Disorder	☐	☐
Structural Disorder (i.e., cleft palate)	☐	☐
Reading Difficulties	☐	☐
Spelling Difficulties	☐	☐
Other (please describe): _______________	☐	☐

Who provided the diagnosis? *Speech-Language Pathologist* ☐ *Physician* ☐ *Other* __________ ☐

How old was the child when the diagnosis was made? ____

Please describe any treatment or special help he/she received. ____

____

____

Who provided the treatment or special help? ____

How old was the child when treatment began? _____________ when treatment ended? _________________

Please describe what the child has worked on in treatment. ____

____

____

How rapid was improvement? *Very slow* ☐ *Moderately slow* ☐ *Steady* ☐ *Rapid* ☐

Current Speech Skills

Does this child currently have problems with his/her speech, or do you have any concerns about this child's speech at the present time? Yes ☐ No ☐

If you checked Yes, please complete the rest of this section. If you checked No, please skip the rest of this section and go to the Current Language Skills section beginning on page 4.

How often can the child's speech be understood by

• parents	*never* ☐	*sometimes* ☐	*usually* ☐	*always* ☐
• brothers/sisters	*never* ☐	*sometimes* ☐	*usually* ☐	*always* ☐
• playmates	*never* ☐	*sometimes* ☐	*usually* ☐	*always* ☐
• other relatives	*never* ☐	*sometimes* ☐	*usually* ☐	*always* ☐
• strangers	*never* ☐	*sometimes* ☐	*usually* ☐	*always* ☐

Please check items of concern:

Difficult to understand	☐	Doesn't talk as well as peers	☐
Talks too fast	☐	Talks too slow	☐
Talks "baby talk"	☐	Avoids talking	☐
Mispronounces words	☐	Stutters	☐

Please answer the following questions:

How often does the child try to self correct his/her speech? *Never* ☐ *Sometimes* ☐ *Often* ☐

How often is the child willing to repeat words after you try to say them correctly?

Never ☐ *Sometimes* ☐ *Often* ☐

How is this child's speech in imitation compared to when s/he says the words by him/herself?

Better ☐ *The same* ☐ *Worse* ☐

How would you describe this child's willingness to repeat his/her idea if it is not understood?

Usually willing ☐ *Often unwilling* ☐ *Always unwilling* ☐

How would you describe this child's willingness to talk?

Usually willing ☐ *Hesitant in many situations* ☐ *Hesitant in most situations* ☐

Has your child's speech improved in the last 6 months? *Yes* ☐ *No* ☐

Please describe the kinds of errors this child is making and/or used to make. Please list some words you can remember this child saying incorrectly (e.g. "at" for "cat," "see" with a slushy sounding '"s").

____

____

____

Please list the kinds of things that you and your family have been doing at home to improve his/her speech:

____

____

____

Current Language Skills

Languages spoken in the home: *English* ☐ *Spanish* ☐ *Other (specify)* ___________ ☐

Does this child currently have problems with language, or do you have any concerns about his/her language skills at the present time? *Yes* ☐ *No* ☐

If you checked Yes, please complete the rest of this section. If you checked No, please skip the rest of this section and go to the Pregnancy and Birth History section at the bottom of this page.

Does this child understand

- short sentences (3-4 words) *Yes* ☐ *No* ☐
- long sentences (at least 8 words) *Yes* ☐ *No* ☐
- one-part directions *Yes* ☐ *No* ☐
- two-part directions *Yes* ☐ *No* ☐
- three-part directions *Yes* ☐ *No* ☐

Does this child have a limited vocabulary? *Yes* ☐ *No* ☐

Does this child call things by the wrong name? *Never* ☐ *Sometimes* ☐ *Often* ☐

Does this child take a long time to think of words? *Never* ☐ *Sometimes* ☐ *Often* ☐

Which of the following does this child use most often?

- complete sentences ☐
- short phrases ☐
- two word units ☐
- one word ☐
- gestures ☐

Pregnancy and Birth History

Did the mother have any illnesses while pregnant with this child? *Yes* ☐ *No* ☐

If yes, please describe what and when: ____

____

____

Did the mother have any accidents while pregnant with this child? *Yes* ☐ *No* ☐

If yes, please describe what and when: ____

____

____

Was there any threat of miscarriage? *Yes* ☐ *No* ☐ If yes, when? ________________________

Length of labor: ______________________________

Delivery position: *Normal* ☐ *Breech* ☐ *C-Section* ☐

Was this child full-term? *Yes* ☐ *No* ☐ If no, gestation age was ________________

This child's birth weight: __________________

Did this child need supplementary oxygen at birth? *Yes* ☐ *No* ☐

Was this child jaundiced at birth? *Yes* ☐ *No* ☐ If yes, how long did it last? __________________

Did this child have any trouble with early sucking or swallowing? *Yes* ☐ *No* ☐

Did this child require tube feeding? *Yes* ☐ *No* ☐

Were there any unusual problems at birth? *Yes* ☐ *No* ☐ If yes, please explain: ______________

____

____

Were there any health problems during the first two weeks of life? *Yes* ☐ *No* ☐ If yes, please explain:

____

____

____

General Developmental History

Please indicate ages (in months) for the following:

Sat alone unsupported	____________	Began crawling	____________
Walked unaided	____________	Undressed self	____________
Dressed self	____________	Fed self with spoon	____________
Toilet trained when awake	____________	Toilet trained when asleep	____________
Had first tooth	____________	Said first word	____________
Began using single words	____________	Began to put 2 words together	____________
Began using short phrases	____________	Began using sentences	____________

Did this child babble and coo during the first six months? *Yes* ☐ *No* ☐

If yes, how much? *a lot* ☐ *moderate* ☐ *a little* ☐

Motor Skills

Does this child have a hand preference? *Right* ☐ *Left* ☐ *No preference, not sure* ☐

Do you currently have concerns about this child's motor skills? *Yes* ☐ *No* ☐ If yes, please explain:

____

____

Have your concerns about this child's motor skills changed as he/she has gotten older?

Yes ☐ *No* ☐ If yes, please explain: ____

____

Has this child ever had occupational therapy? *No, never* ☐ *Yes, but not anymore* ☐

Yes, s/he is currently receiving OT ☐ (OT minutes per week: _____________)

Improvement in OT: *very slow* ☐ *moderately slow* ☐ *average* ☐ *rapid* ☐

Has this child ever had physical therapy? *No, never* ☐ *Yes, but not anymore* ☐

Yes, s/he is currently receiving PT ☐ (PT minutes per week: _____________)

Improvement in PT: *very slow* ☐ *moderately slow* ☐ *average* ☐ *rapid* ☐

Medical History

Name of family doctor: ____________________________________

Doctor's address: ____

Has this child had any of the following illnesses? Please check all that apply and provide age(s).

Pneumonia	☐	Age: _________	Mumps	☐	Age: _________
Influenza	☐	Age: _________	Whooping Cough	☐	Age: _________
Sinus Infections	☐	Age: _________	Scarlet Fever	☐	Age: _________
Chronic Colds	☐	Age: _________	Rheumatic Fever	☐	Age: _________
Asthma	☐	Age: _________	Meningitis	☐	Age: _________
Allergies	☐	Age: _________	Encephalitis	☐	Age: _________
Tonsillitis	☐	Age: _________	Diphtheria	☐	Age: _________
Croup	☐	Age: _________	Convulsions	☐	Age: _________
Headaches	☐	Age: _________	Seizures	☐	Age: _________
Chicken Pox	☐	Age: _________	Head injury	☐	Age: _________
Measles	☐	Age: _________			

Has this child had any of the following surgeries? Please check all that apply and provide age(s).

Tonsillectomy	☐	Age: _________
Adenoidectomy	☐	Age: _________
Mastoidectomy	☐	Age: _________

Please list any chronic, recurrent, or underlying illnesses that this child has: ________________________

____

____

Were any of the illnesses accompanied by a high fever? *Yes* ☐ *No* ☐

If yes, this child's temperature was _________________

How long did the fever last? _________________________________

Please describe any complications: ____

Was this child ever hospitalized? *Yes* ☐ *No* ☐ If yes, when, how long, and why?

____

____

Does this child regularly take any medication(s)? *Yes* ☐ *No* ☐ If yes, please specify:

____

____

Has this child ever had a neurological evaluation? *Yes* ☐ *No* ☐ If yes, please indicate approximate age and findings: ____

____

Has this child ever had any of the following? (Please check all that apply.)

Chewing Problems	☐	Swallowing Problems	☐
Choking	☐	Difficult moving tongue	☐
Drooling	☐	Pooling of saliva	☐

If any of the above items are checked, please indicate approximate ages and more specific information for each. ____

____

____

Does this child have any dental problems (malocclusion, abscesses, etc.)? *Yes* ☐ *No* ☐

If yes, please describe: ____

____

Hearing History

Has this child ever had his/her hearing tested? *Yes* ☐ *No* ☐

If yes, the results were *Normal* ☐ *Abnormal* ☐

If this child has a history of hearing problems, please explain: ______________________

____

____

Has this child ever had ear infections or uninfected fluid in the ears? *Yes* ☐ *No* ☐

If you checked Yes, please complete the rest of the questions in this box. If you checked No, please skip the rest of this section and go to the next box beginning on page 9.

Which ear(s) was/were affected most often? *Right* ☐ *Left* ☐ *Both* ☐

Approximately how many episodes? ______________________________

At what age was the first episode?______________________________

At what age was the **final** episode? ______________________________

Approximately how long did each episode typically last?

1 week ☐ *2 weeks* ☐ *3 weeks* ☐ *Other* ☐ Specify: ______________

During his/her first 18 months of life, approximately how many total weeks would you estimate that this child had an ear infection or non-infected fluid? ______________________________

What medication(s) were used to treat the infection(s)?

Antibiotics	*Yes* ☐	*No* ☐	Name of antibiotic(s): __________________
Cold medicine	*Yes* ☐	*No* ☐	Name of cold medicine(s): ______________
Preventive antibiotics (prophylactics)	*Yes* ☐	*No* ☐	Name of prophylactic(s): ________________

continued on next page

continued from page 7

Were tubes ever considered? *Yes* ☐ *No* ☐

Were tubes ever placed in the ears? *Yes* ☐ *No* ☐

If yes, which ear(s): *Right* ☐ *Left* ☐ *Both* ☐

Does this child currently have tubes? *Yes* ☐ *No* ☐

If yes, in which ear(s): *Right* ☐ *Left* ☐ *Both* ☐

What symptom(s) did you notice when this child had an ear infection or uninfected fluid in the ear(s)? (Please check all that apply.)

A cold and runny nose	☐	Rubbing the ears	☐
Not sleeping	☐	Ear drainage	☐
Pain in the ear	☐	Crying	☐
Doesn't hear well	☐	Inattentiveness	☐
Clinging and inactive	☐	Other (specify)	☐ _______________
None of the above	☐		

What symptom(s) led you to see a doctor? ____

____

Did you respond differently to this child when he/she had an ear infection or uninfected fluid in the ear?

Yes ☐ *No* ☐

If yes, please indicate what you did differently:

I/we talked loudly ☐

I/we looked directly at him/her when talking ☐

Other (specify): ______________________ ☐

Did this child ever have problems with wax in the ears? *Yes* ☐ *No* ☐

If you checked Yes, please complete the rest of the questions in this box. If you checked No, please skip the rest of this section and go to the Educational History section below.

If yes, how often? ____________________

At what age was the problem first noticed? ____________________

At what age was wax build-up no longer a problem? ____________________

Which ear(s) is/are affected? *Right* ☐ *Left* ☐ *Both* ☐

What symptom(s) did you notice when the child had excessive wax? Please check all that apply:

None ☐ Doesn't hear as well ☐

Inattentive ☐ Complains of discomfort ☐

Other (specify) ☐ ____________________

What treatment did you use when this child had excessive wax? ____________________

____

How frequently is/was treatment needed?

Every week ☐ *Every month* ☐ *Every 3 months* ☐ *Other* ☐ ____________

Educational History

Does this child attend school or preschool? *Yes* ☐ *No* ☐

If you checked Yes, please complete the rest of the questions in this section. If you checked No, please skip the rest of this section and go to the Daily Behavior section on page 10.

Name of school: ____________________

Grade (if not in preschool): ____________________

Teacher: ____________________

How does this child feel about school? ____________________

____

List things that your child does well in school (e.g., following directions, reading, etc.):

____

____

List things that the teacher says the child has difficulty with or needs to work on (e.g., following directions, reading, etc.): ____________________

____

Please indicate whether this child has been diagnosed with any of the following:

Cognitive disability ☐ Learning disability ☐

Emotional/behavioral disorder ☐ Auditory processing disorder ☐

Fine motor delay/disorder ☐ Gross motor delay/disorder ☐

Other ☐ Please specify: ____________________

Daily Behavior

Does this child have or did he/she ever have problems sleeping? *Yes* ☐ *No* ☐

If yes, when? ____________________

Please describe: ____________________

____

Does this child have or did he/she ever have problems eating? *Yes* ☐ *No* ☐

If yes, when? ____________________

Please describe: ____________________

____

Does this child have any habits that you would like to change? *Yes* ☐ *No* ☐

If yes, please describe: ____________________

____

____

Please answer each of the following by checking the descriptor that best describes this child:

1.	makes friends easily	*usually* ☐	*sometimes* ☐	*never* ☐
2.	is difficult to manage	*usually* ☐	*sometimes* ☐	*never* ☐
3.	feelings are easily hurt	*usually* ☐	*sometimes* ☐	*never* ☐
4.	is aggressive	*usually* ☐	*sometimes* ☐	*never* ☐
5.	is independent	*usually* ☐	*sometimes* ☐	*never* ☐
6.	is shy	*usually* ☐	*sometimes* ☐	*never* ☐
7.	easily separates from parents	*usually* ☐	*sometimes* ☐	*never* ☐
8.	acts very immaturely	*usually* ☐	*sometimes* ☐	*never* ☐
9.	needs more praise than other kids	*usually* ☐	*sometimes* ☐	*never* ☐
10.	likes to be in control	*usually* ☐	*sometimes* ☐	*never* ☐
11.	has a positive self-concept	*usually* ☐	*sometimes* ☐	*never* ☐
12.	is overly concerned about others' feelings	*usually* ☐	*sometimes* ☐	*never* ☐
13.	is very fearful in new situations	*usually* ☐	*sometimes* ☐	*never* ☐
14.	needs lots of encouragement to try new things	*usually* ☐	*sometimes* ☐	*never* ☐
15.	is quickly frustrated on difficult tasks	*usually* ☐	*sometimes* ☐	*never* ☐
16.	is very thoughtful of others and helpful	*usually* ☐	*sometimes* ☐	*never* ☐
17.	throws tantrums	*usually* ☐	*sometimes* ☐	*never* ☐
18.	acts impulsively	*usually* ☐	*sometimes* ☐	*never* ☐
19.	adjusts slowly to new people and situations	*usually* ☐	*sometimes* ☐	*never* ☐

20.	chooses to play alone	*usually* ☐	*sometimes* ☐	*never* ☐
21.	is cooperative	*usually* ☐	*sometimes* ☐	*never* ☐
22.	is concerned that others do not like him/her	*usually* ☐	*sometimes* ☐	*never* ☐

Additional Comments

Please comment on anything else about this child that was not covered on this form that you think we should know about him/her: ____

____

____

____

____

Please complete the Family History section beginning on p. 12.

Family History – Immediate Family

Please complete the following information on you, your spouse, and your children.

The person completing this form is the (please check):

Mother ☐ *Father* ☐ *Other* ☐ specify: ______________________

Please indicate which family members have or have had any of the problems listed below by checking the appropriate boxes. If you have more than one daughter or son, please indicate which child (or children) has the problem by writing her/his name next to the box(es) you check.

Problem	Family Member			
	Mother	Father	Daughter(s)	Son(s)
Hearing Problems	☐	☐	☐ ____________	☐ ____________
Recurrent Middle Ear Infections	☐	☐	☐ ____________	☐ ____________
Language Problems	☐	☐	☐ ____________	☐ ____________
Speech Problems	☐	☐	☐ ____________	☐ ____________
Reading Difficulties	☐	☐	☐ ____________	☐ ____________
Math Difficulties	☐	☐	☐ ____________	☐ ____________
Learning Disabilities	☐	☐	☐ ____________	☐ ____________
Cognitive Disabilities	☐	☐	☐ ____________	☐ ____________
Motor Problems	☐	☐	☐ ____________	☐ ____________
Psychological Problems	☐	☐	☐ ____________	☐ ____________
Behavior Problems	☐	☐	☐ ____________	☐ ____________
Serious Medical Problems	☐	☐	☐ ____________	☐ ____________
Birth Defect(s)	☐	☐	☐ ____________	☐ ____________
Syndrome	☐	☐	☐ ____________	☐ ____________
Cleft Palate	☐	☐	☐ ____________	☐ ____________
Seizures	☐	☐	☐ ____________	☐ ____________
Inborn Metabolic Error	☐	☐	☐ ____________	☐ ____________
Diagnosed Genetic Disorder	☐	☐	☐ ____________	☐ ____________

Family History – Mother's Family

Please complete the following information on the mother's family.

The person completing this form is the (please check):

Mother (me) ☐ *Father (spouse)* ☐ *Other* ☐ specify: ___________________

Please list mother's/your sisters' first names here: ______________________________________

Please list mother's/your brothers' first names here: ____________________________________

Please indicate which family members have or have had any of the problems listed below by checking the appropriate boxes. If you have more than one sister or brother, please indicate which sister/brother has the problem by writing her/his name next to the box(es) you check.
(NOTE: "Mother" and "Father" in the table below are your children's grandparents.)

Problem	Family Member			
	Mother	**Father**	**SIster(s)**	**Brother(s)**
Hearing Problems	☐	☐	☐ ____________	☐ _____________
Recurrent Middle Ear Infections	☐	☐	☐ ____________	☐ _____________
Language Problems	☐	☐	☐ ____________	☐ _____________
Speech Problems	☐	☐	☐ ____________	☐ _____________
Reading Difficulties	☐	☐	☐ ____________	☐ _____________
Math Difficulties	☐	☐	☐ ____________	☐ _____________
Learning Disabilities	☐	☐	☐ ____________	☐ _____________
Cognitive Disabilities	☐	☐	☐ ____________	☐ _____________
Motor Problems	☐	☐	☐ ____________	☐ _____________
Psychological Problems	☐	☐	☐ ____________	☐ _____________
Behavior Problems	☐	☐	☐ ____________	☐ _____________
Serious Medical Problems	☐	☐	☐ ____________	☐ _____________
Birth Defect(s)	☐	☐	☐ ____________	☐ _____________
Syndrome	☐	☐	☐ ____________	☐ _____________
Cleft Palate	☐	☐	☐ ____________	☐ _____________
Seizures	☐	☐	☐ ____________	☐ _____________
Inborn Metabolic Error	☐	☐	☐ ____________	☐ _____________
Diagnosed Genetic Disorder	☐	☐	☐ ____________	☐ _____________

Family History – Father's Family

Please complete the following information on the father's family.

The person completing this form is the (please circle):

Father (me) ☐ *Mother (spouse)* ☐ *Other* ☐ specify: _______________

Please list father's/your sisters' first names here: ______________________________________

Please list father's/your brothers' first names here: _____________________________________

Please indicate which family members have or have had any of the problems listed below by checking the appropriate boxes. If you have more than one sister or brother, please indicate which sister/brother has the problem by writing her/his name next to the box(es) you check.
(NOTE: "Mother" and "Father" in the table below are your children's grandparents.)

.	Family Member			
Problem	**Mother**	**Father**	**Sister(s)**	**Brother(s)**
Hearing Problems	☐	☐	☐ ____________	☐ ____________
Recurrent Middle Ear Infections	☐	☐	☐ ____________	☐ ____________
Language Problems	☐	☐	☐ ____________	☐ ____________
Speech Problems	☐	☐	☐ ____________	☐ ____________
Reading Difficulties	☐	☐	☐ ____________	☐ ____________
Math Difficulties	☐	☐	☐ ____________	☐ ____________
Learning Disabilities	☐	☐	☐ ____________	☐ ____________
Cognitive Disabilities	☐	☐	☐ ____________	☐ ____________
Motor Problems	☐	☐	☐ ____________	☐ ____________
Psychological Problems	☐	☐	☐ ____________	☐ ____________
Behavior Problems	☐	☐	☐ ____________	☐ ____________
Serious Medical Problems	☐	☐	☐ ____________	☐ ____________
Birth Defect(s)	☐	☐	☐ ____________	☐ ____________
Syndrome	☐	☐	☐ ____________	☐ ____________
Cleft Palate	☐	☐	☐ ____________	☐ ____________
Seizures	☐	☐	☐ ____________	☐ ____________
Inborn Metabolic Error	☐	☐	☐ ____________	☐ ____________
Diagnosed Genetic Disorder	☐	☐	☐ ____________	☐ ____________