INITIAL CASE HISTORY
and
Developmental Profile

For Young Children Who Are
Deaf or Hard of Hearing

SKI-HI Institute/HOPE Inc.

SKI-HI Institute
Utah State University
Logan, Utah 84322

HOPE Inc.
www.hopepubl.com
©2020

INITIAL CASE HISTORY

Date: ______________________ **Information provided by:** ______________________

Interviewer: ______________________ **Relationship to child:** ______________________

I GENERAL INFORMATION

Child's Name: ______________________ Referred by: ______________________

Date of Birth: ______________________ Program: ______________________

Address: ______________________ Phone number: ______________________

____

II FAMILY INFORMATION

Mother's Name: ______________________ Father's Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Telephone: (H) ______________________ Telephone: (H) ______________________

(W) ______________________ (W) ______________________

Occupation: ______________________ Occupation: ______________________

Level of education: ______________________ Level of education: ______________________

Child living with: ______________________

Language/s used in the home: ______________________

(If two languages are spoken, please circle the one used most often)

Other children:

NAME	AGE	SCHOOL / OCCUPATION	GRADE

III HEARING STATUS

1. Was hearing loss present at birth? Yes _____ No ____ Don't know _____

2. When was your child's hearing loss first diagnosed? ______________________________
   By whom/where? ____

3. What was the cause of your child's hearing impairment? __________________________
   ____

4. Has your child ever had earaches or ear infections? Yes _____ No _____

5. Has your child ever had tubes in his/her ears? Yes _____ No _____
   If yes, when/where/ by whom? ____

6. Does any one in your family have a hearing loss? Yes _____ No _____
   Who?____

7. Has your child ever worn a hearing aid? Yes _____ No _____

8. If yes, how old was your child when he/she first used a hearing aid? _______________

9. Does your child have a hearing aid now? ______ Make: _________ Model: ________
   When purchased: _______________ Where purchased: _________________________
   Warranty expires: _______________ Insurance: ______________________________
   Overall is it: Satisfactory: ________ Unsatisfactory: ____________

10. How many hours a day does the child wear the aid(s)? __________________________

11. Do you have an audiologist you see regularly? _______________________________
    Who? _______________________ Where? _______________________________

IV DEVELOPMENTAL / MEDICAL INFORMATION

Pregnancy and Birth

1. Were there any complications or difficulties with the pregnancy and/or birth of your child? Yes _____ No _____ Please describe: ______________________________

   ____

   ____

2. Did you take any medications during pregnancy? Yes _____ No _____

3. What was your child's weight at birth? ______________________________

4. Were there any problems with your child's health or appearance at birth?
   Yes _____ No _____

5. Was there any extra medical attention required? Yes _____ No _____
   For you: _____ For child: _______ Please explain: ______________________________

   ____

Motor Development

1. At what age did your child start to: Sit unsupported __________ Crawl ___________
   Walk unaided __________ Toilet train _________ Feed self with spoon __________
   (Was your child slow, normal, or ahead of other children in most areas? ____________)

2. Do you feel your child is well coordinated? (i.e. crawling, walking, etc.)
   Yes _____ No _____

3. Does your child have problems with fine motor skills? (e.g. buttoning, cutting with scissors, etc.) Yes _____ No _____ Comments: ______________________________

   ____

4. Has your child received physical or occupational therapy? Yes _____ No _____
   Please describe: ____

Speech and Language Development

1. At what age did your child start to:

   cry for attention ________________ vocalize ________________________

   imitate words ___________________ babble __________________________

2. How does your child communicate his wants and needs to family members? (Please check)

   cries ☐ gestures ☐ pulls person to desired objects ☐

   signs, gestures ☐ talks, gestures ☐ talks, signs ☐

   Other ☐ Please describe: ____

   ____

3. Has your child had speech/language therapy? __________ Describe: ____________

   ____

Medical Information

1. Has your child had any of the following illnesses or conditions? (Indicate age occurred)

______ Allergies/Hay fever	______ Ear Infections	______ Meningitis
______ Anemia	______ Head Injuries	______ Migraine Headaches
______ Asthma	______ Heart Disease	______ Mononucleosis
______ Chicken Pox	______ Hepatitis	______ Mumps
______ Convulsions	______ High Fevers	______ Pneumonia
______ Diabetes	______ Hyperactivity	______ Rheumatic fever
______ Epilepsy	______ Measles	______ Other ____________
		____________

Describe treatment, if any ____

____

____

____

2. Please explain reason (accident, surgery, etc.) for any hospitalizations since birth:

____

____

3. Is there any family history of illnesses or medical disorders? Yes _____ No _____
Explain: ____

4. How would you describe your child's current state of health? _______________________

____

5. Is your child presently taking any medications? Yes _____ No _____
If yes, please describe: ____

6. Does your child have any allergies? Yes _____ No _____
Food ________________________ Drugs ________________________________

7. Does your child have any visual problems ? Yes _____ No _____

8. Have eyeglasses been prescribed? Yes ____ No _____
If so, does he/she wear them? Yes ____ No _____

9. Our insurance company is: ____
Our policy number is: __________________ Our medicaid number is: ______________
(Please send copy of current card)

V BEHAVIOR / SOCIAL

1. How would you describe your child's behavior at home? ___________________________

____

2. How does he/she get along with other children? ___________________________
With adults? ____

3. Do you have any discipline problems with your child? Yes _____ No _____

What is usually done to discipline your child? ____________________

____

How effective is it? ____________________

4. Describe your child's disposition or personality. What do you like best about him/her? What would you like to see changed? ____________________

____

5. Describe your child's eating and sleeping habits: ____________________

____

____

VI EDUCATIONAL BACKGROUND

1. List all special programs your child has attended (daycare, preschool, etc.):

Program	City / State	Years

2. Has your child encountered any problems in these programs? ____________________

____

____

____

3. Has your child received previous evaluations from another agency, professional, or school? Yes _____ No _____ If so, where? ______________________________

PLEASE ADD ANY OTHER INFORMATION YOU THINK MAY BE OF IMPORTANCE:

____

____

____

____

____

____

____