

**SPEECH AND HEARING CENTER  
MARSHALL UNIVERSITY  
HUNTINGTON, WV 25755-2675**

**Before you can be given an appointment for a speech, language or hearing evaluation at the Marshall University Speech and Hearing Center, we will need the following information. The information that you provide will be used to plan the most appropriate and thorough evaluation. To avoid any delay in scheduling an evaluation, please fill out this form as completely as possible and return to the above address.**

**Date:** \_\_\_\_\_

**Type of Evaluation Desired:**

\_\_\_\_ **Speech/Language (includes hearing screening)**  
\_\_\_\_ **Audiological**

**Client's Name:** \_\_\_\_\_ **Daytime Telephone:** \_\_\_\_\_

**Sex:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Information furnished by:** \_\_\_\_\_

**Relationship to client:** \_\_\_\_\_

**Name, address and title of person (or agency) who referred you to this Center:**

\_\_\_\_\_

**Has the client ever been examined in this Center before?** \_\_\_\_\_

**If so, when?** \_\_\_\_\_

**Describe in your own words the client's communication problem. Include your opinion of causes or contributing factors.**

**Describe in your own words the client's hearing problem. Include your opinion of causes or contributing factors.**

Do any members of the immediate family, or other relatives, have a speech, language or hearing problem? \_\_\_\_\_

Who? \_\_\_\_\_

Describe:

**HISTORY OF PREGNANCY AND BIRTH**

Describe any illnesses or problems the mother had during this pregnancy.

Total number of pregnancies: \_\_\_\_\_ Which one was the client? \_\_\_\_\_

Have there been miscarriages or stillbirths? Yes/No. How Many > \_\_\_\_\_

What was the length of pregnancy for this child? \_\_\_\_\_

Duration of Labor? \_\_\_\_\_ Birth Weight? \_\_\_\_\_

Was the delivery normal? Yes/No.

Type (name) of anesthetics used: \_\_\_\_\_

Medical condition following birth: \_\_\_\_\_

How was the client's health during the first 2 weeks of life? \_\_\_\_\_

Please circle any of the conditions listed below that apply to the client's delivery.

- Caesarean Delivery
- Forceps Used
- Breech Birth
- Scars or Bruises
- Swallowing Difficulties
- Feeding Problems

- Jaundice
- Anoxia (lack of oxygen)
- Birth Defects
- Seizures
- Sucking Difficulties
- Other: (list)



Operations

Age

Surgeon

Hospital

**Special Conditions:**

**Treatment Received/By Whom/Where**

**Eyesight: Yes/No**

**Hearing: Yes/No**

**Convulsions: Yes/No**

**Cerebral Palsy: Yes/No**

**Mental Retardation: Yes/No**

**Other (specify): \_\_\_\_\_**

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**Did any of the above conditions have complications, either mild or severe, which may relate to the communication or hearing problem?**

**Has the client received previous testing in any of the following areas? If so, please list the full name of the evaluator, place where the evaluation took place, and the date of the evaluation. (If possible, please request that results of any previous testing be forwarded to this Center or bring copies with you at the time of the evaluation).**

**Speech and/or Language: \_\_\_\_\_**

**Hearing: \_\_\_\_\_**

**Neurological: \_\_\_\_\_**

**Psychological: \_\_\_\_\_**

**Academic: \_\_\_\_\_**

**Complete Medical Examination: \_\_\_\_\_**

**Other: \_\_\_\_\_**

**HISTORY OF GENERAL DEVELOPMENT**

Present weight of client:\_\_\_\_\_ Present height of client:\_\_\_\_\_

Has the rate of growth seemed normal? Yes/No

At what age did the child:

Routinely hold up head alone (with stability)?\_\_\_\_\_

Cut the first tooth?\_\_\_\_\_ First crawl?\_\_\_\_\_

Sit alone without support?\_\_\_\_\_ Walk unaided?\_\_\_\_\_

Chew solid food (table food)?\_\_\_\_\_

Feed self with spoon (unassisted)?\_\_\_\_\_

Gain bladder control? (day)\_\_\_\_\_ (night)\_\_\_\_\_

Drink from a glass (unassisted)?\_\_\_\_\_

Use scissors?\_\_\_\_\_ Ride a tricycle or bicycle?\_\_\_\_\_

Use pencil or crayon for drawing?\_\_\_\_\_

Which hand does the client prefer to use? Right/Left

Does the client control body movements with ease? Yes/No

If not, describe:

Was the client slow, average or rapid in general development up to the age of three years?\_\_\_\_\_

**HISTORY OF SPEECH AND LANGUAGE DEVELOPMENT**

During the first six months of life was the client noisy or unusually quiet?\_\_\_\_\_

At what age did the child begin to gurgle and coo?\_\_\_\_\_

At what age did the child begin to respond to the speech of others (by turning head toward the sound, smiling, etc.)?\_\_\_\_\_

At what age did the child say his/her first words?\_\_\_\_\_

What were the first few words the child used consistently, with meaning?

\_\_\_\_\_

**At what age did the child seem to have a name for everything?** \_\_\_\_\_

**At what age did the child combine two or more words into sentences?** \_\_\_\_\_

**Give examples of first few sentences used:** \_\_\_\_\_

**At what age was the child expected to use words (speech) to make his/her wants known to family members?** \_\_\_\_\_

**Did speech development ever stop for any time? Yes/No. When?** \_\_\_\_\_

**Under what circumstances?** \_\_\_\_\_

**How difficult is it for individuals outside the family to understand the child's speech?**

**How does the child react when not understood?** \_\_\_\_\_

**Does the child seem to have difficulty understanding others (Not only the words they are saying, but the meaning of the words.)** \_\_\_\_\_

**When, why and by whom was the child's communication difficulties first noticed:**

**What was done about the problem at that time?** \_\_\_\_\_

**What efforts have been made at home to help the child talk better?** \_\_\_\_\_

**How aware is the child that he/she has a speech or language problem?** \_\_\_\_\_

**How does the child's speech or language problem affect his/her daily living?** \_\_\_\_\_

**Has the child ever had speech or language therapy? Yes/No.**

**Where?** \_\_\_\_\_

**With what results?** \_\_\_\_\_

**Please give an example of a sentence used by your child:** \_\_\_\_\_

**FAMILY HISTORY**

**Mother's Name:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Names and Ages of brothers:**

**Names and ages of Sisters:**

**Names, ages, and relationships of others living in the home:**

**How does the child compare with the brothers and sisters when they were the age that this child is now?**

**Which child has been the most difficult to raise? Please explain:**

**Which child has given the least difficulty?**

**HISTORY OF EDUCATIONAL DEVELOPMENT**

If pre-school, who is the primary care-taker during the day (i.e., mother, babysitter, day-care)? \_\_\_\_\_

What school does the client attend? \_\_\_\_\_

Grade: \_\_\_\_\_ Address: \_\_\_\_\_

Does he/she receive any services other than regular classroom? \_\_\_\_\_

Describe: \_\_\_\_\_

Has he/she ever repeated a grade? Yes/No Which grade(s)? \_\_\_\_\_

Why? \_\_\_\_\_

Has he/she ever failed a hearing screening? Yes/No.

When? \_\_\_\_\_ Where? \_\_\_\_\_

In what subjects does the child do his/her best work? \_\_\_\_\_

Explain: \_\_\_\_\_

What subjects are most difficult? \_\_\_\_\_

Explain: \_\_\_\_\_

How does the child get along with teachers and classmates? \_\_\_\_\_

What other schools has the child attended?

When?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF GENERAL DEVELOPMENT**

Write a paragraph describing your child. For example: Is he/she easy to manage? Does he/she play well with other children? Does he/she prefer to be alone? What things does he/she do well? Does he/she have special problems such as thumb sucking, bed wetting, etc.? (If more space is necessary, attach an additional page.)