!

!

Calvin Speech & Hearing Clinic
On the campus of Calvin University
3201 Burton St. SE, Grand Rapids, MI 49546
spaud@calvin.edu 616.526.6070 p. 616.526.7001 f.

Pediatric Case History

We appreciate your commitment to attend all sessions. Successful treatment depends upon a weekly commitment, and students spend many hours in preparation for each clientÕs sessions. Absence of three or more sessions (2 or more in summer) may result in losing your time slot.

Patient & Family Information

Date of Application:	Clinic program or session applying for: Virtual In person Either Summer Fall Spring
Patient Name: Last	First MI

Other Languages in the Home:

Is there a language other than English spoke in the home? ! No (skip to next section) ! Yes (which one?):	
Does the child speak the language? ! Yes ! No	Who in the home speaks the language?
Does the child understand the language? ! Yes ! No	Which language is the childÕs preferred language?

Other Needs:

Are there any cultural norms that you would like us to know about that may affect delivery of services for your child? ! No ! Yes (explain):
Are there any religious or spiritual needs that would be helpful ous or (i)1 (g) 1.349 0 Td ( )Tj -0.0022 ! Yes (explain)

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

sat alone	babbled	said first words	put two words together
spoke in short sentences	walked	toilet trained	grasped crayon/pencil

Please check which words describe your child:

! affectionate	! demanding	! playful	! overactive	! calm
! good disposition	! shy	! angry	! stubborn	! sad
! curious	! hard to comfort	! likes people	! confident	! fearful
! joyful	! fearless	! other:		

Do you have any concerns about your childÕs (please check which apply):

Height	! yes	! no	! not sure	Vision	! yes	! no	! not sure
Weight	! yes	! no	! not sure	Head Size	! yes	! no	! not sure
Hearing	! yes	! no	! not sure	Movement	! yes	! no	! not sure
Behavior	! yes	! no	! not sure	Speech/Language	! yes	! no	! not sure
Eating	! yes	! no	! not sure	Nutrition	! yes	! no	! not sure
Sleeping	! yes	! no	! not sure	Sensory Processing	! yes	! no	! not sure

Sensory:!

Does your child have any strong preferences and/or consume limited food consistencies? ! Yes ! No	
Does your child crash, bump, jump, or seek physical activity outside what appear typical? ! Yes ! No	
Does your child wear limited clothing textures? ! Yes ! No	Does your child have sensitivities to lights, sounds, or strong smells? ! Yes ! No

Speech & Hearing History

Do you feel your child has a speech problem? ! Yes ! No

Please check areas of concern for speech/language:

! articulation (speech sounds)	! apraxia/motor speech	! speaks in short sentences/phrases
! understanding of language (auditory comprehension)		! social skills/pragmatics
! expressive language/vocabulary	! stuttering (fluency)	! use of a communication device (AAC)
! voice disorder	! dysphagia (swallowing)	! hearing impairment/cochlear implant
! traumatic brain injury (attention/cognition/memory/organization)		

What were they working on?
Is your child receiving speech support through the school system? ! Yes ! No School District and Type:
Do you feel your child has a hearing problem? ! No ! Yes, please describe:

Has your child ever

School History

If your child is in school, please answer the following:

Name of School	Grade in School
What are your childÕs strengths and/or best subjects?	
Is your child having difficulty with any subjects?	
Is your child receiving help in any subjects?	

Additional Comments:

Submit Form:

Mail: Calvin Speech & Hearing Clinic,
Calvin University
3201 Burton St SE
Grand Rapids, MI 49546
Fax: 616-469-1355 By email: spaud@calvin.edu Clinic phone: 616-526-6070
For driving directions to our clinic (North Hall): http://www.calvin.edu/map/