SPEECH AND LANGUAGE CHILD HISTORY FORM

Date:____

Child's Name:____

Child's Age: ____

Date of Birth:____

Grade in School (if applicable):________________________________

Emergency Contact:______________________________(Phone)______________

Person completing this form:________________________________

Relationship to Child:____

Responsible Party's Name and Address:________________________________

Phone: ____

Email:____

Child's Doctor:______________________________(Phone)______________

Sisters and Brothers in the household:

Name: ______________________ Age: ______________________

______________________ ______________________

______________________ ______________________

STATEMENT OF THE PROBLEM

Reason for Referral/Description of Concerns:

____

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____

____

____

What skills do you hope your child will gain if therapy is warranted?

____

____

____

____

Is this the first evaluation for your child? Yes No
If not, who else has seen this child?
Where?____
When?____
Results/Diagnoses____
____

Please explain your child's therapy history (i.e. Occupational Therapy, Physical Therapy, Psychology, etc.).
____
____
____

MEDICAL HISTORY

Were there any problems during pregnancy, birth or delivery? Yes No
If so, please explain:
____

Was your child born prematurely? Yes No
If yes, at how many weeks? ____

Was your child delivered vaginally or via C-section?_____________________________________

Was your child breast or bottle fed? ____

Is there a family history of communication disorders (e.g., speech sounds, language, stuttering)? Yes No
If so, please describe:
____
____

Does your child have a history of recurrent ear/sinus infections or colds? Yes No

Has hearing been tested? Yes No
When and where?____
Results:____

Is your child an oral or nasal breather? Awake________________________ Asleep_______________________

Sleeping posture: Side Back Stomach
Does your child snore? Yes No
Does your child have asthma/allergies? Yes No
If so, please explain: ____________________

Does your child have a history of orthodontics? Yes No
If so, please explain:____________________

Please list any medications your child is currently taking:
____
____

Please describe any medical concerns, injuries, illnesses, or surgeries:
____
____
____

DEVELOPMENTAL MILESTONES

Age child began crawling: ____________________
Was your child an early walker? ____________________
Age child began babbling: ____________________
Age child spoke first words: ____________________
Age child used sentences: ____________________
Age child began conversing: ____________________

Is your child's speech understood by others? Yes No
____
____

HABITS

Does your child have a history of thumb sucking or pacifier use? Yes No
For how long?____________________

Does your child eat a variety of textures and food groups? Yes No
If not, which foods does your child prefer? ____________________
____

INTEREST INVENTORY

What are your child's interests and favorite activities (characters, movies, toys, sports, etc.)?
____

Does your child have any fears (i.e. stuffed animals, loud noises)?
____

Does your child receive special help in school? Yes No
If so, please explain: ____
____
____
____

Is there anything else you wish to add that would help ensure a positive testing experience for your child?
____
____
____