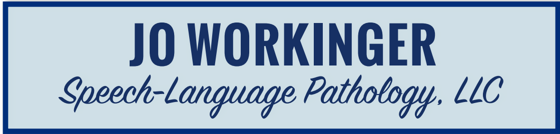

CHILD HISTORY

Date: ________________

General Information:

Child's Name: ______________________________ Birthdate: ______________ Age: ___________

Parent/Guardian Name(s): ____

Siblings & Ages: ____

Address: ____

Phone 1: ____________________ Phone 2: ____________________ Phone 3: ____________________

Email 1: ___________________________________ Email 2: ___________________________________

Parent/Guardian Occupation(s): ____

Other adults in the home? If so, please identify: ____

Emergency Contact (other than adult attending session) - Name: ____________________________

Relationship to Child: __________________________________ Phone: ________________________

Physician: _______________________________ Location: ___________________________________
Phone: __________________________________ Email: ___________________________________

Dentist/Orthodontist: ______________________ Location: ___________________________________
Phone: __________________________________ Email: ___________________________________

Other Specialist: ___________________________ Location: ___________________________________
Phone: __________________________________ Email: ___________________________________

Does your child have existing diagnoses and/or participate in programs or treatments? Y / N

If yes, please list & describe: ____

____

Statement of Problem:

Describe your child's communication difficulty: ____

____

When was the difficulty first noticed?____

How has the problem evolved or changed? ____

Describe any intervention that your child received for his/her communication difficulty: ___________

____

What strategies have been used that seem to help? ____

____

Speech, Language, and Hearing History:

Did your child babble and play with sounds as an infant? ____________________________________

When did his/her first word emerge? _______________________ What was it? ____________________

When did he/she begin to produce 2-word phrases? ____

Your child uses speech to communicate: Always _________ Occasionally _________ Never _________

If your child prefers gestures, please give examples: ____

Describe your child's speech: Sentences _______ Phrases _______ 1-2 Words _______ Sounds _______

Examples: ____

Amount of speech understood by familiar listeners: __________ % unfamiliar listeners: __________%

Describe your child's auditory behavior (response to hearing speech, environmental sounds, noisy environments, following directions, etc.): ____

____

____

Has speech-language been tested in the last 6 months? Yes/No By whom: ______________________

Diagnoses/Recommendations: ____

Was hearing screened or tested (circle one)? By whom? ___________________ When? ____________

Results/Recommendations: ____

Do other family members have speech-language difficulties? Y / N If so, please identify & describe:

____

______________________________ Language spoken in the home: ___________________________

Social and Behavioral Information:

Does your child:

- Make eye contact Y / N
- Respond on topic Y / N
- Interrupt appropriately Y / N
- Stay on topic Y / N
- Ask for information Y / N
- Give information Y / N
- Tell you the names of things Y / N
- Tell you how things are used Y / N
- Describe things and actions Y / N
- Make requests Y / N
- Apologize Y / N
- Protest Y / N
- Show humor Y / N
- Solve problems verbally Y / N
- Greet people Y / N

Is your child:

- Competitive Y / N
- Sensitive to criticism Y / N
- Perfectionist Y / N
- Mature for age Y / N
- Overly sensitive to touch Y / N
- Overly sensitive to sound Y / N

Related Comments: ____

____

What are your child's favorite play/pastime activities? ____

____

How does your child typically play? alone / with other children / fairly equally both ?

Does he/she get along with other children? Y / N / sometimes; with adults? Y / N /sometimes

Is your child easy to discipline? Y / N If no or sometimes to any above, describe: ________________

____

How would you describe your child? ____

____

Birth and Developmental Information:

Age of parents at birth: Mother ______ Father ______ Child conceived through IVF / ICSI ? Y / N

Is your child adopted? Y / N If yes, how old was your child at time of adoption? ________________

Describe the mother's health during pregnancy: ____

Full-term child? Y / N If no, number of weeks of gestation at birth: ____________________________

Birth weight: __________ Describe delivery: ____

Birth injury? Y / N Jaundiced? Y / N Oxygen required? Y / N Heart murmur? Y / N

Nursing Difficulty? Y / N If yes, describe: ____

Describe child's health during first several months: ____

Indicate ages at which your child accomplished the following: Sat alone: __________

Crawled: __________ Stood alone: __________ Walked alone: __________

Bowel trained: __________ Bladder trained: __________ Dressed self: __________

Was child's development hindered? Y / N If yes, describe: ______________________________________

____

Any fine or gross motor difficulties? Y / N If yes, describe: ______________________________

____

Any sleep difficulties or disturbances? Y / N If yes, describe: ______________________________

____

Medical History:

Please indicate if your child has experienced or currently experiences any of the following. Also include relevant details pertaining to **age, duration, severity, treatment** and **outcomes**.

Tonsilitis	Tonsilectomy	Adenoidectomy
Lingual Frenectomy	Hearing Loss	Middle Ear Infections / Earaches
Ear Surgery	Heart Problems	Surgery
High Fevers / Measles	Mumps	Pneumonia
Frequent Colds	Snoring	Upper Respiratory Infections
Allergies	Asthma	Sinus Problems
Headaches	Seizures	Head Injury / Unconscious
GERD (Acid Reflux)	Visual Difficulty/Disturbance	Other Injury

____

____

____

____

Is your child currently under a specialist's care? Y / N If so, for what? ____________________

Is your child taking any medications? Y / N If so, what are they and what are they for? ________

____

Is there smoking in the home? Y / N

Is general health good? Y / N

Feeding History:

Breast-fed? Y / N If yes, how long? ___________ Bottle-fed? Y / N If yes, how long? _____________

Were there early eating problems such as colic, special formula, or difficulty transitioning to table food? Y / N If yes, describe: ____

Does your child drink more than one glass of liquid with meals? Y / N

Does he/she appear to wash food down? Y / N Is he/she a fast / slow / average eater?

Does he/she have digestive problems? Y / N If yes, describe: __________________________________

Does your child chew food adequately? Y / N If no, describe: __________________________________

Does he/she resist foods that are difficult to chew? Y / N If yes, describe: _______________________

Does your child eat a variety of foods, textures, temperatures, flavors? Y / N If no, describe: _______

____

Is your child on a special diet? Y / N If yes, describe: ____

Dental History & Oral Behaviors:

Has your child ever sucked thumb / fingers / pacifier? If yes, until what age & under what conditions? ____

____

Has dental development been on track? Y / N If no, describe: _________________________________

___________________________________ Cavities? Y / N If yes, details: __________________________

Teeth grinding during day / night? Y / N Does your child breathe through nose / mouth / both?

Is mouth open or closed while watching TV, riding in car, doing passive activity, etc.?

Does he/she chew on pencils / shirt / other? If other, describe: _________________________________

Does he/she chew gum excessively? Y / N Does he/she bite fingernails? Y / N

Does he/she lick lips excessively? Y / N Are lips chapped much of the time? Y / N

Educational Information:

School: ____ Grade: ____________

Address: ____ Teacher's Name: __________

Does your child excel in any areas? Y / N If yes, describe: ____________________________

Does he/she struggle in any areas Y / N If yes, describe: ____________________________

Does your child enjoy being read to? Y / N Does your child tell stories well? Y / N

If no, describe: ____

Does he/she read at grade level? Y / N Does your child enjoy reading? Y / N

If no, describe: ____

Does your child spell at grade level? Y / N Does your child enjoy writing? Y / N

If no, describe: ____

How does your child feel about school and his/her teachers? ________________________

____

Is/Has your child been in special programs (Speech, Language, Reading, Special Ed., etc.)? Y / N

If yes, describe: ____

If yes, please list teachers'/specialists' names: ____________________________________

Other Factors:

Please circle any factors that may be related to your child's communication directly.

Anxiety/Nervousness	Autism	BehaviorProblems
Birth Injury/Trauma	Brain Injury	Cerebral Palsy
Difficulties with Attention	Emotional Regulation	Environmental Problems
Epilepsy	Family Trauma	Feeding Problems

Genetics/Heredity	Inconsistency of Parenting	Hearing Loss
Lack of Playmates	Mental Retardation	Neglect by Father
Neglect by Mother	Overprotection by Father	Sensory Integration
Recent Move	Overprotection by Mother	Shyness
Sibling Rivalry	Slow Development	Stubbornness
Visual Disturbances	Other: ______________________________	

Related comments: ____

____

Questions & Additional Information:

Are there specific questions you would like answered about your child? ______________

____

____

____

____

Is there anything else about your child or your family that I should know that might help me provide better service? ____

____

____

____

____

I know this is exhaustive!

Thank you for taking the time to fill out this questionnaire.

2018