



CHILD HISTORY

Date: _____

General Information:

Child's Name: _____ Birthdate: _____ Age: _____

Parent/Guardian Name(s): _____

Siblings & Ages: _____

Address: _____

Phone/ID 1: _____ / _____ 2: _____ / _____ 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

Protest Y / N

Respond on topic Y / N

Show humor Y / N

Interrupt appropriately Y / N

Solve problems verbally Y / N

Stay on topic Y / N

Greet people Y / N

Ask for information Y / N

Is your child:

Give information Y / N

Competitive Y / N

Tell you the names of things Y / N

Sensitive to criticism Y / N

Tell you how things are used Y / N

Perfectionist Y / N

Describe things and actions Y / N

Mature for age Y / N

Make requests Y / N

Overly sensitive to touch Y / N

Apologize 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/Heredit

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.

2023-11