General Information

Child's Name: Date of Birth:

Address: Phone:

City: Zip:

Does the child live with both parents?

Mother's Name: Age:

Mother's Occupation: Business Phone:

Father's Name: Age:

Father’s Occupation: Business Phone:

Referred By: Phone:

Address:

Pediatrician: Phone:

Address:

Family Doctor: Phone:

Address:

Brothers and Sisters (include names and ages):

What languages does the child speak? What is the child's primary language?

What languages are spoken in the home? What is the primary language spoken?

With whom does the child spend most of his or her time?

Describe the child speech-language problem.

How does the child usually communicate (gestures. single words, short phrases, sentences)?

When was the problem first noticed? By whom?

What do you think may have caused the Problem?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does he or she feel about it?

Have any other speech-language specialists seen the child? 'Who and when? What were their conclusions or suggestions?

Have any other specialists (physicians, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions Or suggestions.

Are there any other speech, language, or hearing problems in your family'? If yes, please describe.

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents. medications, etc.).

Length of pregnancy: ______________________________ Length of labor:___________________________________

General condition: ________________________________ Birth weight:______________________________________

Circle type of delivery: head first feet first breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Allergies_________________________	Asthma__________________________	Chicken Pox_____________________
Colds___________________________	Convulsions______________________	Croup___________________________
Dizziness________________________	Draining Ear______________________	Ear Infections_____________________
Encephalitis______________________	German Measles__________________	Headaches_______________________
High Fever_______________________	Influenza________________________	Mastoiditis________________________
Measles_________________________	Meningitis________________________	Mumps__________________________
Pneumonia_______________________	Seizures_________________________	Sinusitis_________________________
Tinnitus__________________________	Tonsillitis_________________________	Other___________________________

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy)

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl ___________________________ Sit _____________________________ Stand___________________________

Walk ___________________________ Feed self_________________________ Dress self _______________________

Use toilet

Use single words (e.g., no, mom, doggie. etc.): ____

Combine words (e.g., me go, daddy shoe, etc.):

Name simple objects (e.g., dog, car, tree, etc.): ______________________

Use simple question~ (e.g., Where's doggie? etc.):

Engage in a convention:

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Are there or have there ever been any feeding problems (e.g., problem with sucking, swallowing, drooling, chewing, etc. If yes, describe.

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.).

Educational History

School:____ Grade:____

Teachers(s):____

How is the child doing academically (or pre academically)?

Does the child receive special services? If yes, describe.

How does the child interact with others (e.g., shy, aggressive, uncooperative, etc.)?

If enrolled for special education services, has an Individualized Educational Plan (IBP) been developed? If yes. Describe the most important goals.

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form:____

Relationship to child:____

Signed:____ Date:____