# SPEECH AND LANGUAGE CHILD HISTORY FORM

Date:_____
Child's Name:_____
Child's Age: _____ Grade:_____
Date of Birth:_____
Parents'/Responsible Party's Name(s):_____
Responsible Party's Address:_____
Phone: _____
Email:_____
Emergency Contact:_____(Phone)_____
Child's Doctor:_____(Phone)_____
Sisters and Brothers in the household:

| Name: | Age: |
|---|---|
| | |
| | |
| | |

Name of the person completing this form:_____
Relationship to child:_____

## STATEMENT OF THE PROBLEM

Reason for referral/description of concerns:
_____
_____
_____

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?
Date of Evaluation: _____
Provider: _____
Results/Diagnoses: _____

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

_____

Is your child currently in therapy? _____
What is the primary goal of this therapy? _____

**MEDICAL HISTORY**

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

_____

_____

Was your child born prematurely? ☐Yes ☐No Gestation Age: _____
Did your child have difficulty feeding/nursing? ☐Yes ☐No
Did your child take a pacifier or suck his/her thumb? ☐Yes ☐No
Does your child keep his/her mouth open at rest? ☐Yes ☐No
Does your child snore or sleep with an open mouth? ☐Yes ☐No Specify: _____
Does he/she wet the pillow with drool while asleep? ☐Yes ☐No
Does your child grind his/her teeth? ☐Yes ☐No
Have you noticed restless sleep/excessive sweating/ postural hyperextension/pause in breathing while he/she is sleeping? ☐Yes ☐No Specify:_____
Is your child a good sleeper/wake feeling rested? ☐Yes ☐No
Does your child have a history of cavities? ☐Yes ☐No
Does your child have allergies? ☐Yes ☐No

Is there any history of medical concerns? ☐Yes ☐No
Please describe any medical concerns, injuries, illnesses, or surgeries:

_____

_____

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

_____

_____

Has your child's hearing been tested? ☐Yes ☐No
Date: _____
Results: _____

Please list any medications your child is currently taking:

_____

**SPEECH AND LANGUAGE DEVELOPMENT**

Age child began babbling: _____ Age child spoke first words: _____
Age child used sentences: _____ Age child began conversing: _____

About how much of your child's speech is understood by others?
☐0% ☐25% ☐50% ☐75% ☐100%

_____
_____

Does your child engage in eye contact? ☐Yes ☐No

Please describe your child's behavior at school/day care: (timid, defiant, cooperative) _____
_____

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

**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)?
_____

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