SPEECH THERAPY DEVELOPMENTAL HISTORY

Your answers to the following questions will help me understand your concerns. Your answers will be regarded as confidential information. Your answers can be short, but if you need more space, please attach extra sheets of paper. Some of the questions may not seem important to you right now, but all this information will help in understanding you and your child's needs.

IDENTIFYING INFORMATION Today's Date:_____

Child's Name: First:_____ Middle Initial:_____ Last:_____

Date of Birth:_____ Sex: M / F

Address:_____ City/State:_____ Zip:_____

Home Phone:_____

PARENT INFORMATION

Mother's Name:_____ Father's Name:_____

Mother's Cell Phone:_____ Father's Cell Phone:_____

Mother's Work Phone:_____ Father's Work Phone:_____

Person filling out this form:_____ Relationship to child:_____

Who referred you here:_____ Child's Pediatrician:_____

Check the area/s in which you have concerns:	**COMMENTS**
_____ Speech/Language	_____
_____ Feeding	_____
_____ Hearing	Has your child's hearing been screened or evaluated? No_____ Yes_____ Date of test: _____ Who performed test: _____
_____ Vision	_____
_____ Height/Weight	_____
_____ Physical Health	_____
_____ Self-Help Skills	_____
_____ Coordination/Motor Skills	_____
_____ Emotional adjustment	_____
_____ Other	_____

Briefly describe speech/language problems: _____

_____

Age when problem was first noticed: _____

MEDICAL & DEVELOPMENTAL HISTORY

Is this your: _____ natural child _____ stepchild _____ adopted child _____ foster child

If adopted, foster or stepchild, at what age did he/she come into your home? _____

If this is your natural child:
How many pounds did mother gain during pregnancy? _____ Length of pregnancy with this child: _____ mos _____ wks

List any medication or shots (if any) mother took during pregnancy:

_____ _____ _____

_____ _____ _____

Did mother experience any of the following during pregnancy? (check all that apply)
_____ illness _____ Rh incompatibility _____ bleeding/spotting _____ vomiting
_____ injury _____ emotional upsets _____ high blood pressure _____ swelling of hands or feet

Describe labor and delivery (check all that apply) **COMMENTS**
_____ Premature birth _____
_____ Spontaneous onset _____
_____ Induced _____ _____
Normal birth _____ _____
Forceps used _____
_____ Breech presentation _____
_____ Anesthesia used _____
_____ C-section _____ _____
Other _____

Condition of baby immediately following birth (check all that apply)
_____ Normal, no difficulties _____
_____ Jaundiced _____ _____
Breathing difficulties _____
_____ Incubation required _____
_____ Convulsions _____
_____ Difficulties feeding, sucking or swallowing _____
_____ Other _____

Measurements of baby at birth: weight: _____ length: _____

Did baby cry immediately? _____ yes _____ no _____don't know

Where was child born? _____ City/State: _____

Were there any problems during the first month at home? COMMENTS
_____ Excessive crying _____

_____ Feeding/sucking/swallowing problems_____
_____ Other _____

AGE **COMMENTS**

At what age did your child do the following?

Smile _____/_____ Sit alone _____/_____

Walk alone _____/_____ Say 1st clear words _____/_____

Toilet trained (daytime) _____/_____

Dressed self _____/_____

Has your child had any of the following?

Measles _____/_____
Chicken Pox _____/_____
Mumps _____/_____
Tonsillitis _____/_____
Ear Infections _____/_____
Allergies _____/_____
Meningitis _____/_____
Other illness _____/_____
Surgery _____/_____
Other hospitalizations _____/_____
Other _____/_____

FAMILY/SOCIAL HISTORY

_____ BIOLOGICAL PARENTS **_____ FOSTER / ADOPTIVE / STEP PARENTS (circle appropriate)**

MOTHER' NAME: _____ Birthdate:_____

Occupation: _____ Grade completed in school:_____

Current marital status: _____ married _____ single _____ divorced _____separated _____widowed

How long married to current spouse: _____

FATHER'S NAME: _____ Birthdate:_____

Occupation: _____ Grade completed in school:_____

Current marital status: _____ married _____ single _____ divorced _____separated _____widowed

How long married to current spouse: _____

SIBLINGS / OTHERS LIVING IN HOME:

Name	**Birthdate**	**Relationship to child**

Language/s spoken in the home: _____ English only _____ English plus: (list other/s): _____

Any developmental concerns in family members, in both immediate and extended family (include speech/language, hearing, global developmental delays, autism, stuttering, etc.) _____ no _____ yes

Please list family member's relationship to your child and a brief statement of the developmental concern:

_____

SCHOOL INFORMATION

School District: _____ Name of School: _____

Address: _____ Grade: _____

Current teacher:_____ Days/Hours attends: _____

Special Programs ever attended by child:

_____ speech therapy // Name of therapist: _____
_____ physical therapy // Name of therapist: _____
_____ occupational therapy // Name of therapist: _____
_____ special classes // Name of teacher: _____
_____ other // Name of therapist: _____

List schools child has attended (including preschool):

Name/Address of School Grade Dates of Attendance

_____

_____

_____

_____

List other persons and places where child has been seen in the past:

Name/Address of Specialist Testing/Treatment Given Dates

_____

_____

_____

_____

List the following information regarding your child:

Regular/organized extracurricular activities: _____
Favorite things (food, toy, activities): _____
Strong dislikes: _____
If in school, best/favorite subjects: _____
Least favorite subjects: _____

Which of the following does your child use to communicate?
_____ gestures _____ single words _____ phrases _____ complete sentences _____ follows directions

How well does your child understand you? _____ good _____ fair _____ poor
How well do you understand your child when you know the context? _____ good _____ fair _____ poor
How well do you understand your child when you don't know the context? _____ good _____ fair _____ poor

What do you hope to gain from this appointment?_____
_____