

Child's name: _____

Child's date of birth: _____

Dear Parent/Guardian:

Please answer the following questions as best you can, and bring this form in with you on the day of your appointment. If you have any questions about a specific piece of information, do not be concerned. The information will be covered during the appointment.

Thank you.

MEDICAL HISTORY

Child's weight at birth? _____ lbs. _____ oz.

Was your child born full term? Yes No

If not, at what week of gestation? _____ weeks or

How many _____ weeks or _____ months early?

What type of delivery?

_____ Vaginal delivery (_____ normal/spontaneous _____ Pitocin induced)

_____ Cesarean section – if so, was this due to:

_____ repeat

_____ fetal distress

How old was the mother at the time of delivery? _____ Years

What number pregnancy was this (e.g. 1st, 2nd, etc.)? _____

If any prior pregnancies, how many resulted in a delivery? _____

Hospital where child was born? _____

Was your child adopted? Yes No

If yes, where was your child born? _____

How old was your child when he/she was placed in your care? _____

Was your child conceived through in vitro fertilization? Yes No

Did the mother receive fertility therapy? Yes No

Was your child a singleton or a multiple birth? Singleton Multiple

If a multiple birth, how many children were delivered? _____

What were their birth weights? _____

Were there any maternal medical problems during the pregnancy? Yes No

If yes, what was/were the problem(s)?

_____ Bleeding _____ Diabetes _____ Infection _____ Hypertension

Were any medications taken during the pregnancy? Yes No

If yes, please list medication(s) and reasons taken? _____

Did you have a fetal sonogram? Yes No

If yes, how many?

Result(s) of sonogram(s)? _____ Normal _____ Abnormal

If abnormal, please explain: _____

Was the infant's stay in the nursery:

_____ uneventful _____ complicated

If complicated, please describe: _____

Did the infant leave the hospital with mother after usual post-partum stay? Yes No

Please list any/all operations, hospitalizations (including emergency room visits) and procedures your child has had”

Procedure

When

Why

Has your child had any severe illnesses? Yes No

Illness

When

Has your child had any chronic illnesses, such as ear infections? Yes No

Illness

Frequency

Duration

Is your child currently taking medications? Yes No

If so, please list medications and reason for taking them: _____

Does you child have known allergies to food or medications? Yes No

If yes, please list: _____

Pediatric care is provided by:

Name: _____

Address: _____

Are your child's immunizations up to date? Yes No

Please list any other health care problems: _____

DEVELOPMENTAL HISTORY

Please list the ages at which your child:

Rolled over _____

Sat up _____

Crawled _____

Stood up _____

Cruised _____

Walked alone _____

Said mama/dada _____

Single words _____

2 - word phrases _____

Toilet trained: During the day _____

At night: _____

Please note where your child attended/attends school:

3-year nursery: _____

4-year nursery: _____

Kindergarten: _____

1st grade: _____

2nd grade _____

3rd grade: _____

4th grade _____

5th grade: _____

6th grade _____

7th grade: _____

8th grade _____

Other: _____

In the current school placement, please indicate the number of students _____,

Teachers: _____, and aides _____

Has your child ever had any of the following evaluations?

Evaluator

Date

General Findings

Audiology: _____

Physical Therapy: _____

Speech & Language: _____

Psychology: _____

Neurology: _____

Occupational Therapy: _____

Other: _____

Has your child received any therapies?

Frequency

Start Date

End Date

Physical Therapy: _____

Speech & Language Therapy: _____

Occupational Therapy: _____

Other: _____

Describe your child's peer interactions: _____

Child usually goes to sleep at _____ PM

Child does / does not sleep through the night

Child gets up / is wakened at _____ AM

Is your child on a special diet? Yes No

If yes, please describe the diet: _____

FAMILY COMPOSITION

Mother's age _____ Occupation _____

Mother's Name _____

Father's age _____ Occupation _____

Father's Name _____

Please list the child's siblings:

* Name _____ age _____ male / female

* Name _____ age _____ male / female

* Name _____ age _____ male / female

* Name _____ age _____ male / female

* Name _____ age _____ male / female

* Name _____ age _____ male / female

Do any family members have developmental delays, learning problems or
psychiatric difficulties? Yes No

If yes, please explain: _____

Please describe your child and any concerns you have regarding his or her development and behavior_____

Speech and Language History

What language(s) does your child speak? What is your child's primary language?

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

Does your child have a speech or language problem? Yes or No
If yes, describe it.

When was the problem first noticed? By whom?

How does your child communicate (gestures, single words, short phrases, sentences?)

Have any other speech-language specialists seen your child? Who and When? What were their conclusions or suggestions?

Has your child had an Audiological Exam? Please provide date and results?

Are there or has there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, different textures, etc.)? If yes, describe.

What Your Child Understands

Describe your child's response to sound:

Does your child react to sounds other than voices?

Yes No

Does your child turn his/her head toward a sound? (e.g., your child may turn his/her head when the telephone rings.)

Yes No

If the object that is making the sound is out of sight, will your child look for the object or towards the directions it is coming from?

Yes No

When someone calls your child's name, does he/she stop what he/she is doing?

Yes No

Does your child look around to find a person who is talking?

Yes No

Does your child put toys in his/her mouth?

Yes No

When you point to a person/object, does your child look at that person/object?

Yes No

When family members extend their hands and say "Come with me," does your child lean forward to go with them?

Yes No

Does your child stop what he or she is doing when someone says "no?"

Yes No

Does your child understand certain words (other than "no") for family members, pets, objects or greetings (for example, your child may raise his or her arms to be lifted when you say "You want up?" or when you say "bye-bye").

Yes No

If yes, what words does your child understand? _____

Does your child play with more than one toy at a time? (e.g., he or she may play with two toys, such as banging a truck and a cup on the table or pretend to give a drink to a bear with a cup.)

Yes No

Does your child follow simple directions, like “go get your shoe?”

Yes No

Does your child follow directions that have several steps, like “pick up our toys and put them away?”

Yes No

Does your child know what objects are used for (e.g., you drink from a cup and you bounce a ball)?

Yes No

Does your child respond to words like “stop” or “wait?”

Yes No

Does your child understand words for parts of the body? Please circle:

Nose Mouth Eyes Tummy Feet Ears
Hands Head Other_____

Does your child understand the words for clothing? (e.g., does your child raise his or her arms when you say, “Let’s put on your coat on?” What words for cloths does our child know? Please circle:

Shoes Socks Pants Shirt Shorts Skirt
Other_____

What Your Child Communicates With You

Does your child make two different vowel sounds, like “a” and “u”?

Yes No

If yes, please identify _____

Does your child make different constant sounds, like “b” and “m”?

Yes No

Circle the sounds your child can make.

P B M N T D K G

Does your child say two sounds together, like “ba” or “bu”?

Yes No

If yes, please identify _____

Does your child wave or greet to say goodbye?

Yes No

Does your child prefer to use words or gestures to let you know what he/she wants?

Yes No

Does your child use words to:

- Ask for something he/she wants to do or request an object

Yes No

- Tell you what he/she is doing

Yes No

- Let you know he/she wants something to happen again

Yes No

- Ask for help

Yes No

- Answer yes/no questions

Yes No

Does your child use question words like “what” or “why”?

Yes No

If yes, please circle:

Who What When Where Why How

How does your child interact with his/her peers (shy, aggressive, uncooperative, etc.)?