Speech-Language Developmental History

Date_____

Person Completing History: mother_____ father____ other (specify)_____

Child's Full Name:_____ ***DOB***:_____

Address: _____ Gender: male____ female____

_____

Parents are: married____ separated____ divorced____ widowed____ single____ other_____

1) Parent's Name: _____ Relation to Child:_____

Occupation: _____ Employer:_____

Phone #: (cell)_____ Phone #: (work)_____

Phone #: (home)_____ Email:_____

2) Parent's Name: _____ Relation to Child:_____

Occupation: _____Employer:_____

Phone #: (cell)_____ Phone #: (work)_____

Phone #: (home)_____ Email: _____

Names and ages of brothers and sisters: _____

_____

Insurance Company:_____ Policy #_____

Group #_____ Insurance (Claim) Address:_____

_____

Referred by:_____

Child's Physician and other Professionals:

Physician: _____ Practice: _____ Phone: _____

Medical Diagnosis (*if any*): _____

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speechnmotion@gmail.com

When was your child's last vision test (or screening)? _____ PASS/FAIL

When was your child's last hearing test (or screening)? _____ PASS/FAIL

Has your child had ear infections? Y/N *If yes, how many and at what age did they start and stop:*

_____

Has your child had tubes in his/her ears? Y/N *If yes, at what age?* _____

Please describe and give approximate dates for any significant illnesses, surgeries, and/or injuries your child has experienced:

_____

_____

Has your child received previous evaluation and/or treatment by a speech therapist? Y/N

If yes, who? _____
Reason(s) for leaving and/or discontinuing treatment (please be specific):_____

_____

PLEASE LIST ANY ALLERGIES, DIETARY MODIFICATIONS, MEDICAL PRECAUTIONS, OR ASSISTIVE DEVICES (PECS, Proloquo) YOUR CHILD MAY HAVE:

_____

_____

Prenatal/Birth History:

Did the mother:

1) Have any infections/illnesses, shocks or unusual stresses during pregnancy? Y/N _____

2) Receive any medication during pregnancy? Y/N _____

3) Have any complications during labor/delivery? Y/N _____ *Was or did child:*

    1) Full term Y/N Weight at birth: _____
    2) Premature Y/N Number of weeks: _____
    3) Breech Y/N
    4) Require forceps, suction or C-section for delivery? Y/N _____
    5) Have any birth injuries, complications, or require NICU treatment after birth? Y/N _____

    _____

    _____

Has your child ever had difficulty with any aspect of feeding (e.g. latching on/accepting bottle, difficulty with certain textures, picky eater)? Y/N *If yes*, *explain*: _____
_____

Developmental Milestones:

(Give approximate ages, or comment on anything unusual)

Breast or bottle fed_____

Cup drinking _____

Straw drinking _____

Sippy cup_____

Solid foods _____

Blowing _____

Babbling _____

Saying words _____

Saying 2-words _____

Saying sentences _____

Rolling over_____

Sitting unassisted_____

Crawling_____

Walking_____

Following simple directions_____

Family History:

Please note any family history of the following diagnoses. Please note **"M"** for maternal side, **"P"** for paternal side, **"S"** for sibling. If possible, please note the relation (e.g. mother, brother, aunt, etc.).

_____ ADD/ADHD

_____ Autism Spectrum Disorder (any)

_____Cognitive Delay

_____Expressive/Receptive Language Delay

_____Late Talker

_____Speech Delay (articulation/speech sounds)

_____Swallowing Disorder

_____Auditory Processing Disorder (APD or CAPD)

_____Apraxia of Speech

_____Anxiety or Mood Disorder

_____Down Syndrome

_____Feeding Difficulties

_____Learning Disabilities

_____Stuttering

_____Voice Disorder

What are *3-5 of your current most pressing concerns* about your child?

Please describe *at least 3-5* of your child's strengths and gifts.

Please describe *at least 3-5 particular skills* you would like your child to gain in the next six months? What do you hope to gain from this evaluation and/or treatment?

You may [ ] call my cell phone [ ] leave me a voice mail [ ] email me [ ] text me

Preferred therapy times:

TIMES	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING					
AFTERNOON					

_____

Signature

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