*Speech * Language * Learning*

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Associate:

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CHILD'S HISTORY FORM Today's Date: _____

Child's Full Name: _____

Date of Birth: _____

Home Address: _____
Street Name City State Zip
Home Telephone#: _____ School:_____ Grade: ____

School District:_____ Principal's Name:: _____

Schoool Telephone #: _____ Teacher's Name: _____

Mother's Full Name:_____ Cell#: _____

Email:_____Occupation:_____

Employer:_____ Business Telephone#: _____

Education: _____

Father's Full Name: _____ Cell#:_____

Email:_____ Occupation: _____

Employer:_____ Business Telephone#: _____

Education: _____

Parents are: Married: ___ Divorced: ___ Seperated: ___ Widowed: ___

I, _____, assume full responsibility for all office charges.

Signature: _____

Do you plan to apply for insurance? Yes No

Brothers and Sisters: (List ALL at home or away)

Name	DOB	Occupation or School	Grade

Other persons living in the home and relationship to the child

Language spoken in the home_____

Has anyone in the family ever had a speech, language, hearing or learning problem? Explain:

Who referred you to this office?_____

Previous medical examinations hospitalizations, psychological testing, speech testing or contact with social work agencies, public health or mental health clinics:

Date	Name/Place	Reason for examination	Results

Has your child ever received a speech, hearing or language evaluation or therapy?
When and where:

Please write a description of the child's problem as you see it. Please include any information that you feel may be helpful: (use the reverse side of page if necessary)

During Pregnancy:

Is the child adopted?_____

Mother's total number of pregnancies_____ Miscarriages:

List any medications taken during pregnancy:

_____

_____

Was there any difficulty during this pregnancy and delivery?

_____

_____

_____

Birth Information:

Premature _____ On time Overdue _____

Was labor induced? _____

Was anesthesia used? _____ Gas _____ Spinal _____ Other _____

Weight at birth _____ Length _____

Did baby breathe promptly? _____Was oxygen required? _____

Incubation? _____ Length of incubation _____

Was baby jaundiced (yellow)? _____ Which day? _____

During Infancy:

Did baby suck well? _____ Choke Easily? _____ Chew well? _____

Did baby eat well? _____

Was baby limp? _____ Stiff? _____ Nervous? _____ Jittery? _____

Did baby cry a lot? _____ Problems chewing? _____

Swallowing? _____

Development: (at what age did each of the following occur?

Sat alone?_____ Talked in single words?_____

Crawled?_____ Talked in 2-3 word sentences? _____

Pulled up?_____ Bowel control?_____

Walked?_____ Bladder control?_____

Fed self?_____ Dressed self?_____

Behavior:

Does he/she appear to hear well?_____ See well?_____

How does he/she get along at home?_____

How does he/she get along at school?_____

How does he/she get along in the neighborhood?_____

Does he/she present any behavior problems?_____

Does he/she have any trouble sitting still? _____

Has he/she had temper tantrums? _____

Bedwetting? _____

Has he/she every required medication for behavior control?

List: _____

_____

Illnesses:

Accidents:_____

Frequent colds?_____

Ear infections?_____

Seizures? _____ Allergies?_____

Treatment? _____ Medication? _____

Measles _____ Age _____ Complications _____

Chicken Pox Age _____ Complications _____

Whooping Cough _____ Age _____ Complications _____

Head Injury _____ Age _____ Complications _____

Has your child ever been hospitalized?_____

Is your child currently enrolled in any therapy or special education program? Explain:

The physician most familiar with your child:

If your child has been or is now in a special education program (speech-language therapy, remedial reading, math, spelling etc.), please have the school send us copies of the evaluation reports and/or of the IEP (Individual Educational Plan).

Today's date: _____

Signature: _____

Relationship to patient: