

CHILD HISTORY QUESTIONNAIRE

I. GENERAL INFORMATION

Date: _____

Child's Name: _____ Birth Date: _____

Address: _____ Phone: _____

Person completing this form: _____ Relationship to child: _____

Language(s) spoken in the home: _____

Is there any other language spoken to the child during the day? _____

By whom? _____

What are your concerns regarding your child's speech, language, and/or hearing?

What question(s) would you like answered as a result of an evaluation here?

Pediatrician or Family Physician: _____ Phone: _____

Insurance Company: _____ Provider # _____

HMO Yes _____ No _____ Prior Approval Required? _____

Medicaid? Yes _____ No _____ Medicaid # _____ Date of Issue: _____

NOTE: All information provided on this form will be held in the strictest confidence.

II. FAMILY HISTORY

Mother: _____ Age: _____

Address: _____ Phone #: _____

Education: _____ Occupation: _____

Father: _____ Age: _____

Address: _____ Phone #: _____

Education: _____ Occupation: _____

Brothers and Sisters:

Name	Age	Sex	Grade	Any Speech, Hearing, Medical Problems
1.				
2.				
3.				
4.				

Have you or anyone else in your family not listed above experienced speech/language, hearing, learning or attention problems? _____

III. BIRTH HISTORY

During this pregnancy or delivery, did mother experience any unusual illness, condition, or accident such as German measles, Rh incompatibility, special medical care, false labor, etc.? _____ If so, please describe: _____

Length of Pregnancy: _____ Birth Weight: _____

APGAR scores (if known): _____

Birth was: Normal _____ Caesarean _____ Breech _____ Multiple Birth _____

Was your child in the Neonatal Intensive Care Unit (NICU)? _____

If so, how long? _____

Please check those conditions that applied to your child immediately following birth:

_____ difficulty breathing _____ sucking problems _____ seizures
 _____ blue skin _____ swallowing difficulties _____ scars and bruises
 _____ jaundice _____ feeding problems _____ cord wrapped around neck
 _____ genetic disorder _____ meningitis _____ AIDS (HIV)

Please describe any unusual events or problems during the first year. _____

IV. SPEECH-LANGUAGE AND HEARING HISTORY

During the first year, other than crying, would you say that your child was:

- a very quiet baby_____ an "average" noisy baby_____
- a quiet baby_____ a noisy baby
- a very noisy baby_____

At what age did you child say his/her first words?_____

Did your child ever start talking, then stop?_____ If so, please describe:_____

Which does your child prefer to use? Sounds____ One or two words____ Phrases____
Complete sentences____ Gestures____ Please give examples: _____

At what age did your child use word combinations like "Want cookie" or "Me out?" _____

At what age did your child use more complete sentences like "Mommy go shopping" or "I fall down?" _____

How does your child's voice sound? Normal____ Too high pitched _____
Too low pitched____ Hoarse____ Nasal_____

Does your child hesitate, "get stuck," repeat, or stutter on sounds or words?_____

Approximately what percentage of the time can your child be understood?

- By parents_____ By siblings_____
- By playmates_____ By strangers_____

Does your child seem to be aware of speaking differently from others? If so, describe:

Does your child seem to have any difficulty hearing?_____

Does his/her hearing appear to vary or is it constant?_____

Does he/she hear less when he/she has a cold?_____

Has your child ever worn a hearing aid?_____ Which ear?_____ How long?_____

Does your child seem to have any difficulty understanding speech or directions? Please describe:_____

VII. PRESCHOOL HISTORY

Does your child attend a pre-school or daycare program and if so, how often?

When did he/she start in pre-school program?

Name of program: _____

Has the teacher ever expressed concern to you about your child's speech, language, or hearing? _____ If so, what were the concerns? _____

How does your child get along with others at pre-school? _____

Any other comments about your child at pre-school? _____

VIII. SCHOOL HISTORY

School now attending: _____ Grade: _____

Address: _____

Teacher's name: _____

What are your child's average grades? _____

Strongest subjects: _____

Weakest subjects: _____

Has your child's teacher(s) expressed concern about your child's speech, language, or hearing? If so, what were the concerns? _____

How does your child get along with the others at school? _____

Does your child have a current IEP (Individualized Educational Program)? _____

If so, please list pertinent staff working with you: _____

Please explain any concerns regarding your child's school performance: _____

IX. OTHER EVALUATIONS

Has your child had a speech-language evaluation prior to this time? _____

When, where, and with whom? _____

What were the results? _____

Does your child receive speech-language therapy now or has he/se ever received it?

What is or was the nature of the therapy? _____

Has your child had a hearing test or central auditory processing evaluation prior to this time? _____

When and where? _____

What were the results? _____

Has your child had a neurological evaluation prior to this time? _____

When and where? _____

What were the results? _____

Has your child had a recent medical examination? _____

When and where? _____

What were the results? _____

X. ADDITIONAL INFORMATION

Are you concerned about any behavioral problems? _____

If so, describe: _____

In your own words, describe your child's personality: _____

If there is additional information that might help us to understand your child and his/her communication better, please describe: _____
