

Please fill in this History Form as completely and accurately as possible and return it to us prior to the evaluation. Use a separate sheet of paper, if necessary.

Date: \_\_\_\_\_

Name of person completing this form \_\_\_\_\_ Relationship to Child \_\_\_\_\_.

**I. IDENTIFYING INFORMATION:**

1. Child's Name \_\_\_\_\_

First

Middle

Last

2. Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_ Sex M F

3. How can we contact you? \_\_\_\_\_

4. Does your child have: AmeriGroup \_\_\_\_\_ WellCare \_\_\_\_\_ Peach Care \_\_\_\_\_ Medicaid \_\_\_\_\_

5. Parents:

Father \_\_\_\_\_ Age \_\_\_\_\_ Education \_\_\_\_\_

Place of Employment \_\_\_\_\_

Position \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother \_\_\_\_\_ Age \_\_\_\_\_ Education \_\_\_\_\_

Place of Employment \_\_\_\_\_

Position \_\_\_\_\_ Work Phone \_\_\_\_\_

6. Parent's Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_

7. Brothers and Sisters:

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_

8. Do all of the above live in the home with the child? (If no, explain) \_\_\_\_\_

9. Others living in child's home \_\_\_\_\_

10. Languages spoken in the home \_\_\_\_\_

11. Primary language the child hears at home \_\_\_\_\_

12. Child referred to this center by \_\_\_\_\_

13. Family Physician or Pediatrician \_\_\_\_\_

**II. BIRTH AND PRENATAL HISTORY:** (Questions apply to birth of the child being seen)

1. Mother's health during pregnancy: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

2. Illness or accidents during pregnancy \_\_\_\_\_

3. Length of pregnancy (Months) \_\_\_\_\_

4. Place of birth (City/State) \_\_\_\_\_ Length of labor (hours) \_\_\_\_\_ Birth Weight \_\_\_\_\_

5. Were there any unusual problems at delivery? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, explain \_\_\_\_\_

**BIRTH/PRENATAL HISTORY CONTINUED:**

- 6. Type of delivery: Normal \_\_\_ Breech \_\_\_ Cesarean \_\_\_ Dry \_\_\_ High Forceps \_\_\_ Other \_\_\_
- 7. Age of mother at time of child's birth \_\_\_\_\_ Age of Father \_\_\_\_\_
- 8. Were any of the following procedures used during the first five days of the baby's life? Spinal tap \_\_\_  
Skull X-ray \_\_\_ Oxygen \_\_\_ Chest X-ray \_\_\_ Blood Transfusion \_\_\_ Incubator \_\_\_\_\_
- 9. Color at birth: Normal \_\_\_ Blue \_\_\_ Jaundice (Yellowish) \_\_\_\_\_
- 10. Any abnormalities or deformities not already mentioned? \_\_\_\_\_
- 11. Did the newborn baby ever have any of the following? (Circle those that apply)  
Fever- Excessive Vomiting- Allergies- Bleeding- Colic-Feeding Problems- Excessive Crying
- 12. Length of stay in the hospital \_\_\_\_\_

**III. DEVELOPMENT:** (Estimate Nos. 1 through 4 as closely as possible)

- 1. At what **age** did the child: Hold up head \_\_\_\_\_ Sit alone \_\_\_\_\_ Stand alone \_\_\_\_\_ Walk alone \_\_\_\_\_  
Feed himself \_\_\_\_\_ Drink from a cup \_\_\_\_\_ Dress without help \_\_\_\_\_ Tie shoes \_\_\_\_\_  
Color within an outline \_\_\_\_\_ Use scissors \_\_\_\_\_
- 2. When was he weaned?(**age**) \_\_\_\_\_ Did he use a pacifier? Yes \_\_\_ No \_\_\_ Until What **age**? \_\_\_\_\_  
Did he suck his thumb or finger? Yes \_\_\_ No \_\_\_ Until what **age**? \_\_\_\_\_
- 3. At what age did he gain control of bladder while awake ? \_\_\_\_\_ While asleep \_\_\_\_\_
- 4. At what age did he gain control of his bowels while awake? \_\_\_\_\_ While asleep \_\_\_\_\_
- 5. Which hand does he use? \_\_\_\_\_ At what age was this established \_\_\_\_\_
- 7. Does he have difficulty using his hands? Yes \_\_\_ No \_\_\_ If yes, explain \_\_\_\_\_
- 8. Does he have difficulty chewing? Yes \_\_\_\_\_ No \_\_\_\_\_ Swallowing? Yes \_\_\_\_\_ No \_\_\_\_\_

**IV. SOCIAL:**

- 1. Does child spend all or part of his day with someone other than parents? Yes \_\_\_ No \_\_\_ If yes, please explain \_\_\_\_\_
- 2. Check all the following that apply: Enjoys being with people \_\_\_ Entertains himself well \_\_\_ Does not play well alone \_\_\_  
Has difficulty concentrating \_\_\_ Is clumsy \_\_\_ Is restless \_\_\_ Is overactive \_\_\_  
Is underactive \_\_\_ Is withdrawn and prefers to be alone \_\_\_ Is unpopular and rejected \_\_\_
- 3. How would you describe the child's temperament? Outgoing \_\_\_ Shy \_\_\_ Easy going \_\_\_  
Difficult \_\_\_ Other \_\_\_\_\_
- 3. Favorite play activities \_\_\_\_\_
- 4. Playmates include: \_\_\_\_\_
- 5. Which best describes your discipline: Firm \_\_\_\_\_ Lenient (easy) \_\_\_\_\_ Inconsistent \_\_\_\_\_
- 6. What form of discipline is usually used? Verbal Reprimand \_\_\_ Time Out \_\_\_ Spanking \_\_\_  
Other (explain) \_\_\_\_\_
- 7. Who usually disciplines the child? \_\_\_\_\_
- 8. Has the child had any emotionally traumatic (shocking) experiences? Yes \_\_\_ No \_\_\_ If Yes, explain and describe the effect on the child \_\_\_\_\_

**V. MEDICAL HISTORY:**

- 1. Present state of child's health: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Poor \_\_\_\_\_
- 2. Medical diagnosis, if any \_\_\_\_\_
- 2. Illnesses (Give **ages** the child had the following): German Measles \_\_\_\_\_ Red Measles \_\_\_\_\_  
Croup \_\_\_\_\_ Scarlet Fever \_\_\_\_\_ Whooping Cough \_\_\_\_\_ Sinusitis \_\_\_\_\_ Rickets \_\_\_\_\_  
Pneumonia \_\_\_\_\_ Diphtheria \_\_\_\_\_ Tonsillitis \_\_\_\_\_ Convulsions \_\_\_\_\_ Mumps \_\_\_\_\_

**MEDICAL HISTORY CONTINUED:**

Ear aches/infections \_\_\_\_\_ Chronic Colds \_\_\_\_\_ Allergies \_\_\_\_\_ Meningitis \_\_\_\_\_  
Encephalitis \_\_\_\_\_ Other illnesses and ages: \_\_\_\_\_

4. Are there any medical conditions that are significantly impacting on the development of the child \_\_\_\_\_  
\_\_\_\_\_  
5. Describe any operations the child has had \_\_\_\_\_  
When? \_\_\_\_\_  
Where was he hospitalized? \_\_\_\_\_
6. ACCIDENTS \_\_\_\_\_ AGE \_\_\_\_\_ HOSPITALIZED \_\_\_\_\_ HOW LONG \_\_\_\_\_  
Yes \_\_\_ No \_\_\_
7. Is Child presently taking medication? Yes \_\_\_ No \_\_\_ Which ones? \_\_\_\_\_

#### VI. EDUCATION:

1. Did/does he attend Preschool? Yes \_\_\_ No \_\_\_
2. Current School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_
3. List schools attended including the locations and dates that your child attended them \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Is he frequently absent from preschool/school? Yes \_\_\_ No \_\_\_ If so, Why \_\_\_\_\_
5. Has he failed grades? Yes \_\_\_ No \_\_\_ If so, which ones? \_\_\_\_\_
6. List any special classes he has attended or tutoring he has received (include Special Education, Occupational Therapy, Physical therapy etc.) \_\_\_\_\_
7. Has your child received Speech Therapy services? \_\_\_\_\_
8. Where and when did he receive Speech Therapy? \_\_\_\_\_
9. What did Speech Therapy work on? (examples: pronunciation of sounds/words, understanding spoken language, increasing the words the child said etc.) \_\_\_\_\_  
\_\_\_\_\_

#### VII. SPEECH AND LANGUAGE HISTORY:

1. Did he coo/gurgle as an infant? Age \_\_\_\_\_ Did he babble as an infant? Age \_\_\_\_\_
2. At what **age** did he first say word(s)? \_\_\_\_\_ What were they? \_\_\_\_\_
3. At what **age** did he name objects/people? \_\_\_\_\_
4. At what **age** did he combine two or more words? \_\_\_\_\_
5. At what **age** did he begin to use sentences? \_\_\_\_\_
6. Did speech learning ever seem to stop for a period? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, please explain \_\_\_\_\_
7. How does he let you know he feels? Laughs \_\_\_ Cries \_\_\_ Smiles \_\_\_ None of these \_\_\_\_\_
8. How does he make his needs known? Speech \_\_\_ Gestures \_\_\_ Both \_\_\_\_\_
9. Does he attempt to imitate speech? Yes \_\_\_\_\_ No \_\_\_\_\_
10. Does he use voice or speech for his own pleasure? Yes \_\_\_\_\_ No \_\_\_\_\_
11. Does he excessively "parrot" or "echo" what is said to him? Yes \_\_\_\_\_ No \_\_\_\_\_
12. Does he speak primarily in whispered speech? Yes \_\_\_\_\_ No \_\_\_\_\_
13. Is his speech understandable to family? Yes \_\_\_\_\_ No \_\_\_\_\_ To others? Yes \_\_\_ No \_\_\_
14. Describe the child's speech problem \_\_\_\_\_
15. At what **age** was this speech problem noticed? \_\_\_\_\_  
Has it improved? Yes \_\_\_\_\_ No \_\_\_\_\_
16. What have you done to help improve his speech? \_\_\_\_\_

- 17. Does he understand what is said to him? Yes \_\_\_\_\_ No \_\_\_\_\_
- 18. Is he ever teased about his speech? Yes \_\_\_\_\_ No \_\_\_\_\_
- 19. Does he hesitate and/or repeat sounds or words? Yes \_\_\_\_\_ No \_\_\_\_\_
- 20. Does he "get stuck" in attempting to say words? Yes \_\_\_\_\_ No \_\_\_\_\_
- 21. Does he have difficulty "finding" word(s) he wants to say? Yes \_\_\_\_\_ No \_\_\_\_\_
- 22. Does he have difficulty pronouncing certain sounds? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, which ones? \_\_\_\_\_

**VIII. AUDITORY BEHAVIOR:**

- 1. Circle all of the following that apply: Responds to most sounds-Responds to loud sounds only  
Responds to sound consistently-Deliberately ignores sounds- Shows fear of sounds-  
Responds to noises but not speech
- 2. Has child ever had his hearing tested? Yes \_\_\_\_\_ No \_\_\_\_\_  
By Whom? \_\_\_\_\_
- 3. Does your child often ask for information to be repeated? Yes \_\_\_\_\_ No \_\_\_\_\_
- 4. Does your child often misunderstand what is said to him? Yes \_\_\_\_\_ No \_\_\_\_\_
- 5. Does your child have difficulty listening in situations where there is background noise like the classroom or when the TV is on at a normal level? Yes \_\_\_\_\_ No \_\_\_\_\_
- 6. Does your child have difficulty following spoken instructions? Yes \_\_\_\_\_ No \_\_\_\_\_

**IX. QUESTIONS:**

What specific questions do you hope to have answered as a result of the speech evaluation?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_