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. MEDICALHISTORY:

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._____