HSDC
Hearing, Speech & Deaf Center

SPEECH, LANGUAGE & LITERACY
CHILD HISTORY FORM

Child's Name_____ Date of Birth_____

I. MAJOR CONCERN(S):

_____
_____
_____
_____
_____

Specific question(s) you would like answered:

_____
_____
_____
_____

II. PRENATAL AND BIRTH HISTORY:

A. During this pregnancy, did the mother experience any unusual illness, accident, or condition, such as German measles, high blood pressure, bleeding, Rh incompatibility? If so, please explain:

_____
_____
_____
_____
_____

B. Was pregnancy full term? ☐ Yes ☐ No If not, please explain:

_____
_____
_____
_____

C. During this pregnancy, did the mother *(please check)*

Smoke? ☐ Yes ☐ No
Drink alcohol? ☐ Yes ☐ No
Take recreational drugs? ☐ Yes ☐ No If yes, please specify_____
Take medication? ☐ Yes ☐ No If yes, please specify_____

D. Was delivery with complications? ☐ Yes ☐ No If yes, please specify_____

_____

E. Did the child have a high bilirubin/jaundice/kernicterus? ☐ Yes ☐ No

If yes, how was he/she treated (lights, transfusion)? _____

How high was the bilirubin count? _____

F. Birth Weight_____ Condition of baby at birth (bruised, jaundiced, difficulty breathing, etc.):

_____

Color good? ☐ Yes ☐ No
Breathed easily? ☐ Yes ☐ No
Incubated? ☐ Yes ☐ No

G. Any feeding difficulties immediately after birth? ☐ Yes ☐ No

If yes, why? _____

My child was ☐ Breast fed ☐ Bottle fed ☐ Both

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III. DEVELOPMENT

A. At what age did the child:

Sit independently_____ Feed self_____ Stop thumb sucking_____
First crawl_____ Walk independently_____ Gain bladder control_____
Wean from bottle_____ Drink from sippy cup_____ Gain bowel control_____
Wean from breast_____ Drink from open cup_____ Stop using pacifier_____

B. Describe your child's:

Overall development_____
Coordination and balance_____
Self-help skills (dressing, washing, etc.)_____
Fine motor skills (using scissors, coloring, writing, etc.)_____
Handedness ☐ Right ☐ Left ☐ Undetermined ☐ Ambidextrous

IV. MEDICAL HISTORY

A. General

Does your child have frequent colds? ☐ Yes ☐ No
History of fevers? ☐ Yes ☐ No
History of ear infections? ☐ Yes ☐ No
Most recent ear infection:_____ How was it treated?_____
Other medical conditions or diagnoses:_____
_____
Is the child in good health at this time? ☐ Yes ☐ No Explain:_____

B. Hearing

Does your child have a suspected or known hearing loss? ☐ Yes ☐ No
Has your child had a hearing test before? ☐ Yes ☐ No
If yes, where?_____
*Results:*_____
Does your child wear hearing aids? ☐ Yes ☐ No If so, for how long?_____
Has your child seen a doctor of an ear examination? ☐ Yes ☐ No When?_____
*Results:*_____ Doctor's Name:_____
Does anyone in your family have a hearing loss? ☐ Yes ☐ No Who?_____

C. Please list all illnesses, accidents, and operations:

TYPE	AGE	DURATION	SEVERITY	HOSPITAL	DATE

D. List any specialists your child has seen. *Please provide name, address, and date:*

Medical Specialist (e.g. neurologist, please specify type):_____
_____
Psychologist:_____
Social Worker:_____
Physical or Occupational Therapist:_____
Speech-Language Pathologist:_____
Audiologist:_____
Other:_____

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V. FEEDING HISTORY

Current feeding abilities (types of food/liquid and how often):_____

_____

Has your ever child gained/lost weight that was considered atypical?_____

Does your child need special spoons or cups? ☐ Yes ☐ No

My child has difficulty with (*check all that apply*): ☐ Chewing ☐ Swallowing ☐ Dislikes certain foods

Examples:_____

VI. SOCIAL/EDUCATIONAL HISTORY

A. Social History

My child prefers to play (*check all that apply*):

☐ Alone ☐ With others ☐ With adults ☐ With older children ☐ With younger children

How does your child get along with other children and adults?_____

Does your child have tantrums frequently? ☐ Yes ☐ No If so, how often?_____

What are some of your child's favorite activities?_____

What types of activities/interactions does your child least enjoy?_____

How would you describe your child's personality?_____

B. Educational History

My child is now enrolled in (*check all that apply*): ☐ School ☐ Preschool ☐ Daycare ☐ None

Name of Daycare:_____ Hours and days per week:_____

Name of School/Preschool:_____ District:_____

Grade:_____ Teacher's Name:_____ Speech Pathologist:_____

Areas of difficulty:_____

Strengths in school:_____

Special therapies or services in school:_____

VII. SPEECH/LANGUAGE

A. At what age did your child do the following:

Begin to babble:_____ Say first word:_____ Put words together:_____

Use short sentences:_____ Examples:_____

B. Current Speech/Language Abilities

Can you usually understand what your child says? ☐ Yes ☐ No Can others? ☐ Yes ☐ No

Is the child aware of her/his speech difference? ☐ Yes ☐ No

Does your child:

Readily imitate sounds, words, and/or sentences you say? ☐ Yes ☐ No

Respond to her/his name? ☐ Yes ☐ No

Point to pictures that you name? ☐ Yes ☐ No

Follow directions? ☐ Yes ☐ No

Ask/answer questions? ☐ Yes ☐ No

Relate events to you? ☐ Yes ☐ No

Understand more than s/he says? ☐ Yes ☐ No

Appear frustrated if s/he is not understood? ☐ Yes ☐ No

Use sign language or gestures to communicate? ☐ Always ☐ Often ☐ Sometimes ☐ Never

Does your child stutter? ☐ Yes ☐ No ☐ Sometimes

Types of stuttering (*check all that apply*):

☐ Whole word repetitions ☐ Syllable repetitions ☐ Sound repetitions ☐ Sound prolongations ☐ Total blocking

How long has this been occurring?_____ How frequently?_____

Does your child frequently have a hoarse voice or lose his/her voice? ☐ Yes ☐ No

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C. Please provide any other information you feel is important for us to know:_____
_____
_____

- Complete this section <u>if there are concerns</u> about delayed speech/language development -

Listed below are words that infants and toddler might understand or say.

- ✓ Put a check beside words you think your child understands.
- ○ Circle the words your child says when s/he talks to you.

All/all gone	Candy	Don't	Grandma	Me	Rock	Thank you
Apple	Car	Done	Grandpa	Milk	See	Thirsty
Arms	Cat/kitty	Down	Gum	Mine	Shhh	Tired
Baby	Chair	Drink	Hair	More	Shirt	Toes
Ball	Cheese	Ears	Hands	More cookie	Shoe	Toys
Balloon	Choo-choo	Eat	Hat	Mouth	Sit/sit down	Truck
Banana	Church	Eat cookies	Hi	Night-night	Sky	TV
Bear (teddy)	Clock	Eyes	Horse/horsy	No	Sleep	Uh-oh
Belly/tummy	Coat	Fall down	Hot	Nose	Snow	Under
Big	Cold	Feet	Hot dog	Old	So big	Up
Bike	Comb	Fingers	Huh?	On	Song	Want
Bird	Cookie	Flower	I	Out	Spoon	Wet
Book	Cracker	Girl	In	Paper	Stick	What?
Boots	Cup	Go	Key	Phone	Stop	What's that?
Boy	Dada/daddy	Go bed	Kleenex	Pizza	Stove	Yes
Bug	Diaper	Go bye-bye	Legs	Please	Swing	You
Bunny	Dirty	Go night-night	Little	Potty	Teeth	yucky
Bye/bye-bye	Dog/doggy	Go out	Mama/mommy	Purse		

List the names of family members, friends, or pets your child says:_____
_____
List any other words or phrases your child says:_____
_____
_____
_____
_____

THANK YOU!
Hearing, Speech & Deaf Center strengthens community by promoting effective communication.