Pediatric History Form

Child’s Name_________________________________________ Today’s Date __________

Date of Birth________________________________________ Age __________ Gender __________

Person Filling out Form ___________________________ Relationship to Child __________________

I. Describe any major concern(s) about your child: ____________________________________________

_____________________________________________________________________________________

II. What specific questions would you like to have answered:

_____________________________________________________________________________________

_____________________________________________________________________________________

III. Prenatal and Birth History:

1. 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 describe: __________________________________________

_____________________________________________________________________________________

2. During the pregnancy did the mother (please check)

☐ Drink alcohol? ☐ Smoke?

☐ Take medication? ☐ Take recreational drugs?

Please describe: __________________________________________

_____________________________________________________________________________________

3. Were there any complications with delivery? ☐ Yes ☐ No

Please describe: __________________________________________

Birth weight:_________ How many weeks gestation at time of delivery: __________

4. Condition of baby at birth (bruised, jaundiced, difficulty breathing, etc.): __________

_____________________________________________________________________________________

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

Incubated? ☐ Yes ☐ No Spent time in NICU? ☐ Yes ☐ No

If yes, please describe length and reason of stay in Neonatal Intensive Care Unit (NICU): __________

_____________________________________________________________________________________

IV. Feeding History

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

If yes, what kind? __________________________________________

My child was ☐ Breast fed ☐ Bottle fed ☐ Both

2. Current feeding abilities (types of food/liquid and how often): __________________________________________

_____________________________________________________________________________________

Has your child ever 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

My child dislikes certain foods: ☐ Yes ☐ No Examples: __________
V. Development

1. At what age did the child:
   - Wean from breast:______  Wean from bottle: _______  Stop using pacifier: _______
   - Spoon feed: _______  Drink from open cup: _______  Feed self: _______
   - Drink from straw: _______
   - Sit independently: _______  First crawl: _______  Walk Independently: _______
   - Gain bladder control: _______  Gain bowel control: _______

2. 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

VI. Medical History

1. General
   - Does your child have frequent colds?  □ Yes  □ No
   - History of fevers?  □ Yes  □ No
   - History of seasonal allergies?  □ 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: _______
   - When was your child’s most recent physical examination? _______
   - Physician: _______  Clinic/Hospital: _______
   - Current medications:
   - Please list all allergies:
   - Please list all illnesses, accidents, and operations:

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<thead>
<tr>
<th>DATE</th>
<th>AGE</th>
<th>TYPE</th>
<th>DURATION</th>
<th>SEVERITY</th>
<th>HOSPITAL</th>
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2. Hearing
   - Does the child have a suspected or known hearing loss?  □ Yes  □ No
   - Does anyone in the child’s biological family have a hearing loss?  □ Yes  □ No
     - Please list _______
   - Has your child had a hearing test before?  □ Yes  □ No
     - If yes, where? _______  When? _______
   - What were the results?______
   - Does your child wear hearing aids?  □ Yes  □ No  If yes, for how long? _______
   - Has your child seen a physician for an ear examination?  □ Yes  □ No
     - When? _______  Results: _______
     - Physician: _______  Clinic/Hospital: _______
VII. Social/Education History

1. Social History
My child prefers to play (check all that apply):
- [ ] Alone
- [ ] With Others
- [ ] With Adults
- [ ] With Older Children
- [ ] With Younger children
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? ____________________________________________

2. 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: ___________________________
Teacher's Name: __________________________ Grade: ___________________________
Speech Pathologist: _______________________
Strengths in school: _________________________
Areas of difficulty: ___________________________
Special therapies or services in school: __________________________

VIII. Speech/Language

1. History
Do you have any family history of speech/language delays or disorders?  [ ] Yes  [ ] No
If yes, please specify: _______________________________________________________________
At what age did your child do the following?
Begin to babble: ___________ Say first word: ___________
Put words together: ___________ Use short sentences: ___________
Examples: __________________________

2. Current Speech/Language Abilities
Can you usually understand what your child says?  [ ] Yes  [ ] No
Percentage of understanding:  [ ] 100%  [ ] 75%  [ ] 50%  [ ] 25%  [ ] 0%
Can others understand what your child says?  [ ] Yes  [ ] No
Percentage of understanding:  [ ] 100%  [ ] 75%  [ ] 50%  [ ] 25%  [ ] 0%
Is your 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
If yes, how is this frustration expressed? ___________________________________________________
Use sign language or other gestures to communicate?  [ ] Yes  [ ] No
Sometimes
3. **Stuttering**
   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?  

4. **Voice**
   Does your child frequently have a hoarse voice or lose her/his voice?  
   - [ ] Yes  
   - [ ] No  

5. **Other Therapy Services**
   Please list all current and previous services, including evaluations, and therapy sessions.  
   Example: Speech pathology, physical therapist. *Please provide name, address, and date*
<table>
<thead>
<tr>
<th>Dates</th>
<th>Age</th>
<th>Service Type (Speech, OT, PT):</th>
<th>Provider:</th>
<th>Location:</th>
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6. Please list any other speech/language concerns, or any information you feel is important for us to know.  
   ____________________________________________
   ____________________________________________
   ____________________________________________

IX. **Special Health Considerations/Precautions**

   HSDC Staff will review charts and pay special attention to any disclosed healthcare needs (e.g., seizures, pacemaker, diabetes, etc.) Please describe any special precautions or procedures we may need to know in case of emergency:
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________