



## Patient History – Child

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Person Completing This Form: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Native language of child \_\_\_\_\_

Languages spoken in the home \_\_\_\_\_

Who referred you for the evaluation? \_\_\_\_\_

### Other children in the family

Name	Age	Sex	Grade in School	Speech/language delays

Does anyone else in the family have speech, language, or hearing problems?  Yes  No

If yes, please describe: \_\_\_\_\_

Has the child had any previous testing or therapy for speech, language, or hearing problems?

Yes  No

If yes, name of agency and date tested \_\_\_\_\_

What was he/she working on?: \_\_\_\_\_

*(Please request that copies of all test results be sent to our office)*

Medical diagnosis: \_\_\_\_\_

What are your speech/language concerns?

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When did you first become concerned with his/her speech and/or language skills?

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Does your child become frustrated when they are not understood?  Yes  No

How much of your child's speech do you understand?  100%  75%  50%  less than 25%

How much of your child's speech do others understand?  100%  75%  50%  less than 25%

Please select the statement that best describes how your child communicates:  gestures/pointing  
 sounds  single words  2-3 word sentences  4-5 word sentences  5+ word sentences

Other:

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### MEDICAL HISTORY

Weight of child at birth Was the child full term?  Yes  No

Were there any complications during the pregnancy or delivery?  Yes  No

If yes, please describe:

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Has your child had or been diagnosed with any of the following (please check all that apply):

ear infections (how many\_\_\_)  ear tubes  asthma  hearing loss  Thumb sucking  
 tonsillectomy/ adenoidectomy  seizures  allergies  head injury  vision problems

Has your child seen a specialist for any reason?  Yes  No If yes, please explain:

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Has your child been hospitalized, had a serious accident or had an operation?  Yes  No  
If yes, please explain:

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Has the child had a hearing screening/evaluation?  Yes  No

When and results: \_\_\_\_\_

Do you currently have hearing concerns? \_\_\_\_\_

Has the child had a vision assessment?  Yes  No

When and results: \_\_\_\_\_

Do you currently have any vision concerns? \_\_\_\_\_

### DEVELOPMENTAL HISTORY

In early childhood, did the child have any feeding problems (such as poor control of sucking, food allergies, digestive upsets)?  Yes  No

If yes, please describe: \_\_\_\_\_

Give ages of development for the following behaviors:

Sat alone	_____	babbled	_____
crawled	_____	said first word	_____
walked	_____	put two words together	_____
potty trained	_____	spoke in 3 short sentences	_____

Does your child follow simple directions?  Yes  No

Does your child answer questions (who, what, when, where, why, how)  Yes  No

Does your child ask questions?  Yes  No

Does your child play with other children?  Yes  No

### EDUCATION HISTORY

Current School \_\_\_\_\_

Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

Does your child have an Individual Education Plan (IEP)  Yes  No \_\_\_\_\_

What do you see as your child's strengths? \_\_\_\_\_

What do you see as your child's challenges? \_\_\_\_\_