Speech/Language Developmental History Form

Client information:

Name_____ Date of Birth _____Age_____

Form Completed by_____ Date_____

Parents/Legal Guardian (check all that apply)
With Whom does the child live? Both parents_____ Mother____ Father_____
Stepfather/Stepmother___ Other _____ If so, who?_____

Parents/Legal Guardians Name:

Address:_____

Home phone_____, Work phone_____

cell phone_____

Are there any languages other than English spoken at home: No_____ yes _____

What languages?_____ By whom_____ How

often? _____

Areas of Concern (Check all that apply)

Behavioral/emotional _____ Listening_____

Immature language _____Difficulty understanding language_____

Health/medical_____ Speech difficult to understand_____

Vision problems _____ Uneven development_____

Slow motor development_____ Stuttering_____

Why are you requesting this evaluation?

Did anyone suggest that you refer your child? If so, please list name and

title. _____

Has a physician, psychologist, speech pathologist, or other diagnostic specialist evaluated your child?

Please list resource/s and any diagnostic impressions determined._____

Preschool/daycare programs attended.

Name_____ Dates_____

Name_____Dates_____

List any special services that our child has received (Head Start, Child Find programs, Speech, occupational or other forms of therapy.

Developmental History:

Pregnancy and Birth: Which pregnancy was this? _____
Was it normal?_____

Please explain any complications. _____

_____

Was your child Full term _____ premature _____What was the length of labor?_____

Was the delivery induced? _____Cesarean_____

Birth weight_____ Baby's condition at birth (jaundice, breathing problems etc_____
_____
_____

Motor Development: Please list appropriate ages.

Sat alone_____ Crawled _____Stood Alone_____
Walked independently_____ Fed self with a spoon_____
Toilet Trained: Bladder_____ Bowel_____

Medical History:

List any significant past or present health problems (serious injury, high temperature or fever, any twitching or convulsions, allergies, asthma, frequent ear infections etc.)

List any medications taken on a regular basis.

List medical treatments (e.g. PE tubes, inhalers, ear wax removal)

Speech and Language Development:

List appropriate ages:
Spoke first words that you could understand_____ (mama, dada)
Used two word sentences_____ Spoke in complete sentences_____

Does your child communicate primarily using speech? _____
Does your child communicate primarily using gestures? _____
Is your child's speech difficult for others to understand? _____
Does your child have difficulty following directions? _____

Does your child have difficulty answering questions? _____

Audiological information:
Has your child's hearing been evaluated? _____
Hearing Screen administered at school _____ Date_____
Hearing evaluation completed by an audiologist_____ Date_____

Social Development:
What opportunities does your child have to play with children of his/her age?
_____
_____
_____
_____
_____

What play activities does your child enjoy?
_____
_____
_____

Does she/he play primarily alone? _____

Do you have any concerns about your child's behavior?
_____
_____
_____
_____

Please provide any additional information you feel may be helpful regarding the evaluation /therapy process for your child.
_____
_____
_____
_____
_____
_____
_____
_____