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 (circle all that apply)

Behavioral/Emotional Slow motor development Listening Stuttering

Difficulty understanding language Health/Medical Vision Problems

Speech difficult to understand Uneven development Immature Language

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 your 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 or premature (circle one)

What was the length of labor? _____________

Was the delivery induced? _______________ Caesarean ________________

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, iinhalers, 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 by 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 he/she 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 evaulation/therapy process for your child.

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____
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