



DEVELOPMENTAL SPEECH AND LANGUAGE HISTORY

Parents: This history may appear to be quite long. However, a number of the questions require checking off responses, which can be done quickly. This information is very useful in gaining a clear understanding of your child's strengths and weaknesses. We appreciate your time.

Person Completing History: Mother Father Self Other (specify) _____

General Information:

Child's Full Name: _____ Birth Date: _____

Address: _____ Gender: male _____ female _____

_____ Phone #: _____

Child's Race: Caucasian African Am. Hispanic Asian Native Am. Other (specify) _____

Is child adopted? Yes No Foster Child? Yes No

Parents are: married separated divorced widowed single other (specify) _____

Parent's Name: _____ Relation to Child: _____

Occupation: _____ Employer: _____

Phone #: _____

Parent's highest education completed: less than high school high school grad some college/associates

bachelors post-graduate doctoral/post-doctoral

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Names and ages of brothers and sisters: _____

Others living in the house (include names and relationship to child/family): _____

Emergency Contact Person: _____

(Name) (Relationship) (Phone #)

Teacher's Name: _____ School: _____

Grade in School: _____ Type of classroom: _____

Referred by (name, address, profession): _____

Medical Information:

Child's Physician and other Professionals: (continue on back of page if needed)

Physician: _____ Address: _____ Phone: _____

Other: _____ Profession: _____ Phone: _____

Other: _____ Profession: _____ Phone: _____

Other: _____ Profession: _____ Phone: _____

Medical Diagnosis:

_____ ADD/ADHD _____ Anxiety Disorder or Mood Disorder, specify: _____

_____ Autism _____ Cognitive Delay

_____ Down Syndrome _____ Emotional Disorder, specify: _____

_____ Fragile X Syndrome _____ Learning Disabilities, specify if possible: _____

_____ Tourette's Syndrome _____ Non-Verbal Learning Disability

_____ Pervasive Developmental Disorder (PDD)

_____ Other, specify: _____

Has child received **previous evaluation** and/or treatment by a Speech and Language Pathologist? _____

If yes, when and where: _____

Has child had a **vision** test? _____ If yes, when? _____

Has child had a **hearing** test? _____ If yes, when? _____

What were the **results** of hearing and vision tests? _____

Has your child had any of the following? If yes, describe and give approximate dates.

Childhood diseases or major illnesses: _____

Congenital abnormalities: _____

Surgery: _____

Serious injury: _____

Casts or braces: _____

Ear infections: _____

Tubes in ears: _____

Allergies: _____

Seizures: _____

Other: _____

List any medications your child is **currently** taking, its purpose and frequency of the dosage:

Medication: _____ Purpose: _____ Freq. of dosage: _____

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Medical information continued:

Has your child received medications **in the past** for any of the above-mentioned conditions?

Medication: _____ Purpose: _____ Dates Taken: _____

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Medication: _____ Purpose: _____ Dates Taken: _____

Are there any medical **precautions** the therapist should be aware of when working with your child?

Does your child have any assistive devices (e.g., glasses, casts, wheelchair)? _____

Has your child received other evaluations or treatment (school, psychological, private therapist or clinic, neurology, nutritionist, GI consult, allergist, etc.)? If so, what type, when, and by whom?

Type	Eval. Date	Professional's Name	Dates of therapy
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What do you hope to gain from this evaluation and/or treatment? _____

Mother's Health During Pregnancy:

Did the mother:

1) have any infections/illnesses during pregnancy? Yes No

Describe: _____

2) have any shocks or unusual stresses during pregnancy? Yes No

Describe: _____

3) receive any medication during pregnancy? Yes No

If yes, what kind: _____

4) any complications during delivery/labor? Yes No

Describe: _____

How does your child usually communicate (gesture, words, etc)? _____

When was the problem first noticed? By whom? _____

Has the problem changed since it was first noticed? Explain how: _____

Is your child aware of the problem? How does he/she feel about it? _____

Are there any other speech, language, hearing problem in the family? If yes, please describe: _____

Play Skills:

1) What are your child's favorite play things? _____

2) What does she or he do with these toys? _____

3) Who does child prefer to play with and how does your child interact with others (e.g. shy, aggressive, etc)? _____

4) What activities does the child least enjoy? _____

5) Are there any things that your child tends to fear or avoid? Yes No

If yes, describe: _____

6) How long does child play with one toy? _____

7) Does your child tend to play while in one position more than others do? Yes No

If yes, what position? _____

8) Does your child tend to play with things by lining them or piling them up (if over two years of age)?

Yes No Describe: _____

9) What extra-curricular activities is your child involved in (i.e., gymnastics, swimming lessons, Scouts, etc.)?

How is your child doing academically/pre-academically? _____

Does your child receive special services? If yes, describe: _____

Please tell us about your child's strengths and gifts: _____

What in particular would you like your child to achieve? _____

How, if in any way, would you like to interact differently with your child? _____

Signature

Date

