CENTER FOR SPEECH, LANGUAGE, AND LEARNING INC.

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CHILD HISTORY FORM

The information you provide us with will help us develop a sense of who your child is and how you, as a parent, experience your child. This helps us to know more about what we need to ask you as well as helps us develop appropriate assessment and intervention plans, as necessary. Thank you for taking the time to be thorough!

Child's Name:		Today's Date:
Date of Birth:	Age:	School District:
School:	Teacher:	
Grade:	School Speech Therapist/OT Names:	
Languages spoken in the home:		

Reason for contacting our office: (What are your main concerns?)
Current Diagnoses (of any kind) and if educational or medically determined:
Assessment or Intervention History (Occupational Therapy, Speech Therapy, Physical Therapy, Vision Therapy, psychological). Please provide pertinent reports.
Is your child on an IEP, IIIP, or IFSP? If yes, please provide a copy of their most recent IEP/IFSP.
Describe any allergies or food sensitivities:
List all medications your child currently takes: Name: Dosage / Frequency: Purpose:

Describe any prenatal complications and birth complications (Pre-terms, breach, c-section, forceps, low apgar score, jaundice, NICU etc.):

Delivery Type: Vaginal C-section Forceps

What was your child's birth weight? Lbs. ounces

Describe any feeding difficulties currently or during infancy. For example, avoidance of certain textures, drooling, difficulties with swallowing, chewing, or sucking.

Indicate whether your child has met the following milestones, and at what age they first displayed each skill.

Roll over from stomach to back and back to stomach:

Sit independently:

Crawl: Did they skip crawling?: Did they crawl on 4-points (hands/knees):

Walk:

Speak his/her first word: What was it:

Combine words:

Speak sentences:

Drink from a cup independently:

Toilet trained:

Toilet trained through the night:

Feed self with a spoon independently:

Dress self independently:

Difficulty with Bathing: (doesn't tolerate?)

Sleep Difficulties currently: Getting to sleep: Staying asleep:
What helps?:

Hand dominance/preference (left or right): Do they switch?:

List any infancy or early childhood concerns your pediatrician may have noted. For example, torticollis, hypo or hypertonia.

Check any that apply:

- ☐ Seems clumsy (awkward, flops in seat, poor posture, etc.)
- ☐ Falls often
- ☐ Tires easily
- ☐ Walks on toes
- ☐ "W" sits
- ☐ Poor ball skills
- ☐ Appears weaker than peers
- ☐ Has difficulty learning new motor tasks

List any significant childhood illnesses, surgeries or injuries:

Does your child have a history of frequent **ear** aches or ear infections? Describe:

Does your child have a history of PE tubes in his or her ears? Describe age of placement(s) and current status:

Describe the results of your child's last **hearing** screening or test:

Has your child had his/her **vision** tested? If so, describe the concerns and result:

Where was this completed: (at school, or eye dr.)

Check any that apply:

- ☐ Rubs eyes frequently
- ☐ Eyes tired at the end of the day
- ☐ Complains of eyestrain or headaches
- ☐ Trouble copying from board
- ☐ Holds things close to eyes
- ☐ Makes reversals when writing, copying or reading

Does your child use any adaptive or home therapy equipment? Describe:

Describe your child related to sensory needs, unusual sensory responses, and sensory defensiveness to touch, sound, texture, odors, or level of stimulation:

Describe your child's emotional and behavioral attributes:

Check any that apply:

- ☐ Is mostly quiet
- ☐ Is overly active
- ☐ Talks constantly
- ☐ Impulsive
- ☐ Is restless
- ☐ Is stubborn
- ☐ Over reacts
- ☐ Is resistant to change
- ☐ Is usually happy
- ☐ Fights frequently
- ☐ Has difficulty separating from primary caretaker
- ☐ Is easily frustrated
- ☐ Has unusual fears
- ☐ Rocks self frequently
- ☐ Has frequent temper tantrums. Describe:
- ☐ Has nervous tics or habits. Describe:

Describe what your child likes to do and what their strengths are:

Describe what your child dislikes:

Describe your child's ability to understand what is said to him/her AND how your child expresses his/her wants, needs, and ideas:

Check any that apply:

- ☐ Has difficulty sequencing information
- ☐ Has difficulty following directions
- ☐ Has difficulty learning new tasks

Describe how your child interacts socially with family, peers, and adults:

Check any that apply:

- ☐ Plays with toys differently from other children his or her age. Describe:
- ☐ Knows and talks about special interests at length, to the exclusion of other topics, and without regard to the listener. Describe:
- ☐ Has difficulty understanding nonverbal communication (facial expressions, gestures, physical space, tone of voice) or seems unaware of those communication cues.

Does anyone in your family have a history of speech, language, or learning difficulties? Describe:

Is there a family history of related physical or emotional diagnoses? Describe:

Describe your goals for your child.

I would like to see my child be able to…

Speech and Language therapy examples: "talk clearly, use more words, follow directions. "
Occupational therapy examples: "dress independently, tolerate more sensory experiences, use his/her hands better."

Thank you for your time and attention to this information!