



Speech and Language History Form

Child's Name: _____ Nickname: _____

Parent's names: _____ Address: _____

Contact information: (phone) _____ Email: _____

Primary Care Physician: _____ Referring Physician: _____

Reason for this evaluation: _____

Siblings:

Name _____ Age: _____ Living at home: _____

Name _____ Age: _____ Living at home: _____

Name _____ Age: _____ Living at home: _____

Birth History:

How many weeks was the pregnancy: _____ Weight at birth: _____

Were there any complications: Yes No _____

Medical History:

Has your child completed a hearing screening and/or evaluation? Yes No Results: _____

Does your child have a history of ear infections: Yes No PE tube placement? Yes No

Do you feel your child hears well? Yes No _____

Any concerns with vision: Yes No _____

Please check any of the following your child has experienced:

___ Allergies ___ Asthma ___ Frequent Coughs ___ Frequent Colds/Congestion

___ Tongue Tie ___ Snoring ___ Difficulty Sleeping ___ Eating Difficulties

Surgeries or hospitalizations: _____



Developmental History:

Approximate age your child:

Sat up _____

Crawled _____

Walked _____

Babbled _____

First words _____

Combined words _____

If you cannot recall the ages, do you feel milestones were reached when you expected them to be? _____

Communication and Behavior:

Can your child follow 2-step directions (i.e. put your jacket away and go get a book)? _____

How much of what your child says can you understand? (Percentage) _____

How does your child react if you do not understand what they have said?

How does your child primarily communicate with you? (i.e. speaking, pointing, grunting, leading you to objects)

Is your child experiencing frustration surrounding communication? (please explain)

Does your child transition easily between activities? _____

Does your child engage with others during play? Take Turns? Use Imaginary Play?

Does your child make eye contact? Seek out others for play?

Does your child attend a daycare or preschool program? _____

Do you have behavioral concerns? _____

Tell me about your child! (Favorite indoor and outdoor activities, preferred toys, daily routine, etc....)
