Child History Form

Demographic Information

Child's Name: _____	Date of Birth: _____ Age: _____
Child's Address: _____	Child's Insurance: _____
Parent/Caregiver Name: _____	Parent/Caregiver Phone Number: _____
Other Parent/Caregiver Name: _____	Other Parent/Caregiver Phone Number: _____
Child's Primary Care Doctor: _____	Child's Primary Care Doctor Phone Number: _____

What are the parent's concerns? (please check all the apply)

____Speech (articulation/ stuttering)	____Language (understanding/ expressing)	____Social Skills (eye contact/ imitating/play)	____Swallowing (chewing/eating/ drinking)	____Feeding (nursing/bottle feeding)

Has your child previously been evaluated for the above concerns?

___ No	___ Yes. If yes, when was the evaluation? _____

Does your child attend school/daycare?

___ No	___ Yes	School/daycare name:_____ Grade/Class: _____ Days/Hours child attends: _____ Does your child receive speech therapy at school? _____

Who does your child live with? (please check all the apply)

____Mother	____Father	____Grandparent(s)	____Twin Sibling	____Older Sibling(s)	____Younger Sibling(s)
____ Other: _____					

What are your child's interests?

_____

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Birth History

How many weeks gestation was your child born? _____ Weeks

What was your child's birth weight? _____ lbs, _____ oz

How was your child delivered? (please check all that apply)

___Natural Delivery without Epidural	____ Natural Delivery with Epidural	___ Cesarean Section	___ Assisted delivery (forceps or vacuum)

Were there any birth complications? (please check all the apply)

___ Jaundice	___ Intubation	___ Infection	___ Hypoxia	___ Preeclampsia
___ NICU Length of stay:_____	Other: _____			

Medical History

Has your child ever been diagnosed with a medical condition, syndrome or disorder?

___ No	___ Yes. Please specify: _____

Has your child ever been diagnosed with tongue, lip or cheek ties?

___ No	___ Yes. Please specify type/if revised: _____

Does your child have any allergies (food or latex)?

___ No	___ Yes. Please specify: _____

Is your child up-to-date on his/her vaccinations?

___ No	___ Yes

Is your child currently taking any medications?

___ No	___ Yes. Please specify type(s) of medication and what it is taken for: _____ _____ _____

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Has your child ever had his/her hearing tested? (please check all that apply)

_____ No	_____ newborn hearing screening ____ Passed ____ Failed	___ school hearing screening ____ Passed ____ Failed	___ formally tested (audiogram) ____ Passed ____ Failed

Does your child have a history of ear infections and/or tubes?

_____ No	_____ Yes. Never had PE tubes	___ Yes. Had PE tubes.

Language History

When did your child say his/her first word?

___ 9-11 months	___1 year	___ 2 years	___3 years	___Not yet

When did your child start combining words (example: “mama go”)?

___1 year	___ 2 years	___3 years	___4 years	___Not yet

When did your child start responding to his/her name?

___ 1-2 months	___3-5 months	___6-9 months	___Not yet	___ Don’t remember

When did your child start following simple commands (example: “look over there”)?

___1 year	___ 2 years	___3 years	___4 years	___Not yet

Did your child ever display a loss of language (i.e., said words before then stopped)?

___ No	___ Yes. Please specify when this occurred: _____

Social History

When did your child start smiling and looking at you when you talked?

___ 1-2 months	___3-5 months	___6-9 months	___Not yet	___ Don’t remember

Does your child display any of the following? (Please check all that apply)

____Lack of shared interests	____Guiding your hand to objects	___Lack of eye contact
____Limited pointing/gestures	____Distress over change in routine	____Repetitive play

Are you concerned your child may display signs of autism?

___ No	___ Yes. Please specify: _____

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Speech/Articulation History:

When did your child start babbling?

___ 3-4 months	___5-6 months	___7-9 months	___Not yet	___ Don't remember

How well do you and people close to your child (siblings) understand your child?

_____ less than 25% of the time	___ 25% - 50% of the time	___ 50% - 75% of the time	___ 75% - 90% of the time	___90% - 100% of the time

How well do unfamiliar people (new friends, strangers) understand your child?

_____ less than 25% of the time	___ 25% - 50% of the time	___ 50% - 75% of the time	___ 75% - 90% of the time	___90% - 100% of the time

Feeding/Swallowing History

How was your child fed for the first 6 months of life?

Breast Fed	**Bottle Fed**	**Tube fed**
Length of time: _____	Length of time: _____	Length of time: _____
Any complications: _____ _____	Any complications: _____ _____	Specify type: _____ _____

When was food introduced? (please check one)

____ 3-4 months	____ 5-6 months	___ 7-8 months	___ 9-10 months	_____ Not Yet

Did your child have any difficulties when solid foods were first introduced?

___ No	___ Yes. Please specify: _____	_____ N/A

How does your child currently consume liquids? (Please check all that apply)

___ Open cup	___ Cup with llid	___ Sippy cup	___ Straw cup	___ Baby Bottle
___ Breast	___Water Bottle	_____ Not Yet	Other: _____	

Does your child cough/choke while eating or drinking?

___ No	___ Yes. Please specify: _____	_____ N/A

Does your child have difficulty accepting a variety of foods?

___ No	___ Yes. Please specify: _____

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Anything else you would like to tell us about your child?

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to fill out this history form.
We are looking forward to working with you and your child!