

Date: \_\_\_\_\_

Name of Person Completing this Report: \_\_\_\_\_

Referred By: \_\_\_\_\_

Family Physician: \_\_\_\_\_

**A. General History:**

**Client**

Name	Birth Date	Age	Grade	Sex	Child Lives With:

**Siblings**

Name	Age	Grade	Sex	Speech, hearing, or other medical problems

**Mother**

**Father**

Name:	Name:
Address:	Address:
Phone:	Phone:
Highest level of Education:	Highest level of Education:
Occupation:	Occupation:

**B. Why are you seeking services from SpeechCare, Inc.?**

What is the problem?	
When was the problem first noticed?	
What do you think caused the problem?	
What has been done about it?	
How does your child react to the problem?	
How do you and others in the family react to this problem?	

**C. Pregnancy and Birth History:**

Were there any illnesses or accidents during pregnancy?	
What was the length of labor?	
Were there any unusual problems at birth?	
Weight of child at birth:	
Was the child "blue" at birth?	
Was the child Jaundiced at birth?	
Describe any health problems during the first two weeks of infant life?	
How was the infant fed, breast or bottle?	
Describe any feeding problems	

**D. Child's Development: At what age did the following occur?**

	Months		Months
Held head erect while lying on stomach		Had first tooth	
Sat alone unsupported		Had all baby teeth	
Crawled		Walked unaided	
Fed self with spoon		Dressed and undressed self	
Completely toilet trained when awake		Completely toilet trained when asleep	

**E. Child's Educational History:**

School Name:	Grade:
Address:	Teacher:
Phone:	How is your child doing in school?
Does your child like school?	
Does your child have therapy at school? If so, what kind?	

**F. Has your child received any of the following therapies? Please Check.**

Physical Therapy	Behavioral
Occupational Therapy	Counseling
Hearing	Nutritional
Psychological	

**G. Medical History: If yes, please explain if medical treatment was needed**

	YES	NO	IF YES PLEASE EXPLAIN
Frequent respiratory infections?			
Frequent earaches or ear infections?			
Excessively high fever?			
Other?			
Has your child been hospitalized for any illness?			
Is your child currently receiving medication? If yes, what medication and why?			
If your child is receiving medication what is its effect on your child?			
Does your child have any allergies? If yes, explain in detail.			
Does your child have any other conditions not listed?			
Are you concerned about your child's hearing?			
Do you notice any changes in hearing from day to day?			
Is your child's hearing poorer when he/she has a cold?			

Has your child ever been diagnosed with any of the following:

Diagnostic Label	YES	NO	Who Diagnosed	When	Do You Agree
Low muscle tone					
Mental Retardation					
Autistic/PDD					
Cerebral Palsy					
Down Syndrome					
Brain Damaged					
Learning Disabled					
Developmentally Delayed					
Neurologically Impaired					
Hearing Impaired					
Vision Impaired					
ADD, ADHD					
Other:					

## H. Speech History

At what age did your child begin to babble and coo?	
At what age did he/she speak his first word?	
At what age did your child begin to use two-word sentences?	
What were your child's first few words?	
Does your child use speech frequently, occasionally or never?	
Does he/she prefer to use speech or gestures?	
Does your child prefer to use complete sentences, phrases, one or two words, or sounds?	
Is your child understood by his siblings? By his parents?	
Is your child understood by his playmates and classmates?	
Does your child make sounds incorrectly? If yes please explain which sounds.	
Does your child hesitate and/or repeat sounds or words?	
Does your child get stuck in attempting to say words?	

## I. Daily Behavior

Does your child eat well?	
Does your child sleep well?	
Does your child get along with other children? Adults?	
Does your child have difficulty concentrating?	
Is it difficult to discipline your child?	
What types of discipline are most effective?	
What types of discipline are least effective?	
What activities and playthings does your child enjoy?	

If there is any other information about your child you would like to share, please feel free to write on the back of this sheet. Thank you for taking the time to complete this form.