Communication Matters

A Professional Corporation

Speech-Language Pathology

"Enhancing Lives Through Communication"

Child Information Form

Date:_____

CHILD'S FULL NAME: _____
Last First Middle Nickname

Address:_____

Age:_____ Date of Birth:_____ Sex: M____ F____

MOTHER'S NAME: _____

Telephone: Home ( )_____ Work: ( )_____

Address(if different from child):_____

Occupation: _____ Education: _____

First language: _____ Other languages spoken: _____

FATHER'S NAME: _____

Telephone: Home ( )_____ Work: ( ) _____

Address(if different from child):_____

Occupation: _____ Education: _____

First language: _____ Other languages spoken: _____

Child lives with:_____ Relationship:_____

Number of persons in household: _____

Person completing this form: _____ Referred by: _____

Child's Physician: _____Telephone: ( )_____

Address: _____

Child's Dentist: _____Telephone: ( )_____

Address: _____

Description of problem:

Please describe the child's problem and the reason/s for asking for this appointment: _____

_____

_____

Has the child ever received speech therapy? When? Where? What results?

_____

_____

_____

_____

_____

_____

_____

_____

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List other agencies, psychologists, audiologists, occupational therapists, physical therapists or physicians who have evaluated and/or treated the child.

Name	Date(s)	Findings/Treatment

MEDICAL HISTORY:

Condition of mother during pregnancy:
Serious illnesses: _____ When:_____
Length of pregnancy: _____
RH blood factors of Father: _____Mother:_____
Prolonged emotional stress:_____
Medications taken: _____
In Vitro Fertilization or Fertility Drugs?: _____
Other unusual conditions: _____
_____

Conditions during and following birth:
Place of birth _____
Duration of labor:_____ Birth weight: _____
Type of delivery: _____ Instruments used: _____
Any injuries, bruises, deformity of head: _____
Breathing difficulties: _____ Feeding difficulties: _____
In incubator or ICU isolation: _____ Jaundice or Anoxia: _____
Other unusual conditions: _____
_____

HISTORY OF CHILDHOOD ILLNESS: (Give age and severity)

Measles: _____ Asthma: _____
Mumps: _____ Allergies:_____
Scarlet Fever: _____ Diabetes: _____
Pneumonia: _____ Epilepsy:_____
High Fevers:_____ Meningitis:_____
Chronic Colds:_____ Encephalitis:_____
Tonsilitis:_____ Seizures:_____
Respiratory Problems:_____ Other:_____
Ear Infections:_____ _____

EAR PROBLEMS:

How many:_____ Right Ear:_____ Left Ear:_____
When:_____ Treatment:_____
Complaints of pain, itching in ear? Yes____ No____ Discharge from ear? Yes____ No____

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EAR PROBLEMS CONTINUED:

Hearing fluctuations (Describe)_____

Tubes in ears? Yes____ No____ When?_____ Which ear?_____

HOSPITALIZATIONS:

Reason: Age: _____ _____

CURRENT MEDICAL PROBLEMS:_____

Is the child taking any medication now?_____

If so, what medication, how often, and for what condition?_____

ACCIDENTS OR INJURIES: (Please describe and give age)

FAMILY HISTORY:

Please give a brief description of health (illnesses/injuries, speech and/or hearing problems, learning disabilities, emotional problems):

Father:_____

Mother:_____

BROTHERS AND SISTERS OF CHILD:

Name Age School grade completed Any problems (medical/learning)

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List any illnesses/injuries, speech and hearing problems, or learning disabilities of other relatives, or others living in the household:

Name: Relationship: Description of difficulty:_____ _____

_____

_____

_____

Does anyone in the family speak any language other than English? Yes____No____
If yes, what language is spoken and by whom?

_____

Does the child understand or speak this language? Yes___ No___

DEVELOPMENTAL AND SOCIAL HISTORY:
At what age did the child:

Sit alone:_____ Walk alone:_____ Begin self-feeding:_____ Toilet train:_____

Does the child have any physical disabilities or impairments?

_____

Are there any problems managing the child?

_____

_____

Does the child play with other children?

_____

_____

Does the child have any food sensitivities, food preferences, food allergies, or restrictions?

_____

Describe play behavior (age of friends, types of play, etc.):

_____

_____

_____

Briefly describe the child's personality (happy, withdrawn, nervous, temper tantrums, etc.)

_____

Any unusual behavior:
Overactive for age:_____ Highly distractible:_____
Bedwetting:_____ Restless Sleep:_____
Rocking, staring, banging head, other: _____
How would you rate the child's learning ability?_____
What are the child's special interests or hobbies?_____

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SPEECH-LANGUAGE HISTORY:

At what age did the child begin to:
Make repeated sounds/Babble:_____
Use first meaningful words:_____
Use two and three word phrases:_____
Use complete sentences:_____

How does the child make needs and wants known to others? _____
_____

Is the child's speech difficult for the family to understand? _____
For others?_____

Does the child have any difficulty understanding what others are saying? _____
Do you use gestures to make the child understand? _____

Does the child:
Use incorrect sounds in words:_____ Use incorrect words:_____
Leave out words:_____ Talk too fast:_____ Stutter:_____
Use no speech at all:_____ Have unusual voice quality:_____
Depend mainly on signs and gestures instead of speech:_____
Other (explain): _____

DEVELOPMENTAL AND SOCIAL HISTORY:

Did the child ever learn to talk and then stop talking?_____
Describe what happened: _____
_____

What, if anything, has been done about the child's speech up to now and with what results?
_____
_____

Are there any problems with:
Teeth:_____ Palate:_____ Throat:_____ Tongue:_____
Other:_____

What do you think might be the cause of the child's speech/language problem?
_____

Is the child aware of the speech/language problem?_____

HEARING HISTORY:

Do you think the child hears well?_____
If not, when was the problem first noticed?_____

Has the child's hearing become worse?_____
If so, over what period of time? _____

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HEARING HISTORY, CONTINUED:

Does the child seem to hear better at certain times than others?_____
If so, when?_____

Does the child seem to hear better in one ear than the other?_____
Which ear seems better?_____

Has the child's hearing ever been tested before?_____
Where?_____ Results:_____

Has the child received medical treatment for ear/s or hearing problem? _____
If so, when?_____

Doctor's name and address:_____
Doctor's finding and treatment:_____

Does the child <u>have</u> to watch your face to understand you?_____

Does the child respond to:

Own name:_____ Vibrations:_____
Soft speech and noises:_____ Gestures:_____
Verbal commands:_____ Loud noises only:_____

Does the child appear alarmed or annoyed by loud sounds?_____

Does the child seem to ignore sounds?:_____

Has the child ever worn a hearing aid?_____
Brand:_____ Which ear:_____

VISION HISTORY:
Do you think the child sees well?_____

Has the child's vision ever been tested?_____
If so, what were the results?_____

Does the child wear glasses or contact lenses?_____

EDUCATIONAL HISTORY: (Including pre-school and day care):

School:_____ Year:_____
Teacher's name:_____ Grade:_____
School:_____ Year:_____
Teacher's name:_____ Grade:_____
School:_____ Year:_____
Teacher's name:_____ Grade:_____
School:_____ Year:_____

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EDUCATIONAL HISTORY, CONTINUED:

Teacher's name:_____ Grade:_____

Has the child ever repeated a grade?_____

How is the child doing academically?_____

In what areas, if any, is the child having difficulty?
_____
_____

Has the child ever received any special services in school? _____ When: _____
If so, what? _____

Has the child had any intelligence tests?_____ If so, when?_____
By whom?_____
Results: _____
_____

Does the child enjoy going to school? _____ If not, please explain why: _____
_____

What subjects does the child enjoy most? _____
The least?_____

Is there anything else we should know about your child?_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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