PEDIATRIC HISTORY FORM
Confidential

Identifying Information:

Childs Name:		Date:
Age:	Sex:	Birth Date:
Mother:		Phone:
Father:		Other Phone:
Address:		Insurance:
School:		Referred By:
Name of Person Completing This Form: Relationship to Child:		

Nature of the Problem (Describe your child's problem as fully as possible):

Family Information

Mother's Occupation: Education: Age: Speech, Language or Learning Related Problems?	Father's Occupation: Education: Age: Speech, Language or Learning Related Problems?
Child lives with: Σ both parents; Σ father; Σ mother; Σ other	
Other adults living in the home:	
Who usually lakes care of your child?	
Children in the family:	

Name	Age	Sex	Speech, Language or Learning Related Problems?

Child's Development

Birth History

Mother's health during pregnancy:	
Pregnancy duration:	Birth weight:
Special Considerations: Σ Prolonged Σ Induced Σ Breach Σ Caesarean Σ Twin (1st/2nd) Σ Premature Σ Other	
Baby's health (color, jaundice, bruises, breathing problems, incubator, abnormalities):	
Feeding problems?	

Hearing:

Do you think that your child has a hearing problem? If yes, explain:	
Has your child's hearing been tested? **Y/N**	By whom?

Findings:		
Tubes in ears:	Date inserted:	Date removed:

Vision

Have child's eyes been examined? **Y/N**	Wear glasses? **Y/N**	By whom?
Findings:		

Motor Development

At what age did your child:			
Sit without support		Go up stairs one foot after the other	
Crawl		Drink from cup, no help	
Walk, holding on to furniture		Eat with utensils	
Walk alone		Gain Bladder Control	
Jump		Gain Bowel Control	
Check any that apply:			
Trips easily		Climbs poorly	
Afraid of climbing		No Fear	
Clumsy with hands		Runs into things	
Any other motor concerns?			
Any concerns with biting, drinking, chewing, or swallowing? (Please explain):			
Any food allergies/preferences? (Please explain):			

Health History

Child's physician:	Phone:	Address:
Others:		
Date of last Physical Exam:		
Current Medications: (Name, Dosage, Reason)		
Is child receiving any physical and/or occupational therapy now? **Y/N** Why?		Where:

Medical Background

Please indicate which of the following apply, age and duration:

Adenoidenectomy		High fevers	
Allergies		Influenza	
Asthma		Measles	
Blood Disease		Meningitis	
Chicken pox		Mouth breather	
Chronic colds		Mumps	
Convulsions		Muscle disorder	
Cross-eyed		Nerve disorder	
Croup		Orthodontia	
Dental problems		Pneumonia	
Diphtheria		Rheumatic fever	
Drooling		Scarlet fever	
Ear infections		Tonsillectomy	
Encephalitis		Tonsillitis	
Headaches		Vision	
Head injuries		Whooping cough	

If you checked any of the above or we did not list a condition you feel is important, please describe:

Speech and Language

What were child's first words: Examples:	Age:
First two-word phrases: Examples:	Age:

How many words can your child say? Σ 1-10 Σ 10-50 Σ 50-100 Σ 100-300 Σ 300-500 Σ Over 500

Give a few examples of phrases and/or sentences that your child typically uses at this time?

What percent of the time is the child's speech understood by:

Mother	Father	Brothers & Sisters	Friends	Teachers	Other relatives

Does your child customarily communicate by use of: Σ Gestures Σ Pantomime Σ Sounds Σ One or two words Σ Phrases Σ Complete sentences

Does your child understand and/or speak another language other than English? If yes, explain:

Which is the predominant language at home?

Was there ever a time when our child's speech and language skills regressed or he/she stopped talking? When? Describe the circumstances:

How do your child's current speech and/or language concerns interfere with:

School setting:

Home environment:

Interpersonal Relationships (Social Skills)? (e.g., playing with other children)

Have speech and language skills been evaluated before?	When?	Where?
Did the evaluation lead to any treatment?	When?	Where?

By whom?

Neurological Development

Has you child had a neurological exam?	When?	For what reason?
Name, Address, Telephone of Neurologist:		

Please indicate which of the following apply, age and duration:

Nervousness	
Aggressive	
Annoyed by loud sounds	
Bedwetting	
Easily upset	
Excessive shyness	
Fearful of new situations, strangers or sitters	
Head banging	
Hurts self	
Hyperactive	
Nightmares	
Perseverative behavior (doing things over and over)	

Persistent habits (nail biting, thumb sucking, nose picking)	
Restless	
Restless	
Rock or roll	
Sad	
Sensitive to being touched	
Short attention span	
Sleeplessness	
Staring at lights or objects	
Temper tantrums	
Tics	
Withdrawn	

How are these concerns manifested at home?

At school?

Educational Development

Schools attended (including preschool):	Grades:	Dates:
Grades repeated		
Current school placement:		
Name:		
Address:		
Phone:	Teacher:	Grade
Child's attitude about current school program:		
Does your child have an iFSP? First Steps services? YES NO What services does your child receive through this program? PT OT SLP SI How many times a week?		
Does your child receive IEP services in school?		
Who provides? SLP OT PT	How many minutes per service?	How often?
Special services (e.g., tutoring) received privately:		
Who provides? Address: Telephone:	What subjects?	How often?

Social Development

Describe your child's personality:
What are his/her favorite activities?
Describe any social problems your child has with friends or family.
What information are you hoping to obtain as a result of this evaluation?
Any other comments that you feel will be helpful in evaluating your child's speech: