SPEECH CENTER OF SOUTHERN ARIZONA

CHILD INFORMATION AND HISTORY

Who is completing this questionnaire? Relationship to Child:

Today's date:

Child's name: Date of Birth:

Please list other programs or therapies in which your child has participated including screening or evaluation:

How did you hear about us?

What is your biggest concern?

Sounds or words your child has difficulty saying:

What have you tried?

What help would you like from us?

You want report sent to:

FAMILY

Child lives with:

How do you describe your child, i.e. personality, temperament?

How would you describe your relationship with your child?

Describe your child's relationship with other parents and siblings:

Please list child's brothers, sisters and any others living in the home, include ages:

Where is your child during the day?

Your school district? School: Y / N School Speech Therapy? Y / N Minutes/week:

Which language(s) does your child hear on a regular basis?

Hours per day in car seat?

Hours of "screen time": (i.e., TV, video games, computer): TV: a.m. p.m. Video games: a.m. p.m.

Computer: a.m. p.m. Phone/hand-held games: a.m. p.m.

Hours of large movement play daily: Hours of quiet time: nap daily:

Child's favorite family activities:

BIRTH HISTORY

Born at _____weeks gestation Pregnancy complications Y / N < Describe Below >

Was your child premature? Y / N Cesaerian Y / N Concerns at birth? Y / N Birth weight:

Did baby stay in the ICU? Y / N Length of ICU/hospital stay: APGAR scores if known:

Had difficulty sucking or feeding? Y / N Breast fed? Y / N Tongue Tie? Y / N

Colic? Y / N Vomiting Y / N GERD (Relux)? Y / N Surgery? Y / N

Low muscle tone: Y / N Seen by Specialists? Y / N Physical or Occupational Therapy? Y / N

Medical History

Please list any medications your child regularly takes:

Other than at birth, has your child ever stayed in a hospital overnight or been treated at an emergency room?

Please explain:

Please describe your child's overall health in the past year:

Please describe any feeding problems your child has experience:

Very selective? Y / N Choking? Y / N Difficulty moving to solid foods? Y / N

The following questions pertain to <u>your child at anytime since birth:</u>

Yes	No	Balance problems?	Yes	No	Oral habits? (thumb, pacifier, nail biting)
Yes	No	Trouble seeing?	Yes	No	Large tonsils?
Yes	No	Trip easily?	Yes	No	Passed newborn hearing screening?
Yes	No	Run into things?	Yes	No	Has your child ever had trouble hearing?
Yes	No	Sit close to TV?	Yes	No	Are you concerned about hearing now?
Yes	No	Frequent upper respiratory infections? (colds, nasal congestion)	Yes	No	Has your child had a hearing test?
Yes	No	Has your child had his/her tonsils or adenoids removed?			Where: Date:
Yes	No	Frequent sore throats or strep throat?	Yes	No	Has your child had ear infections?
Yes	No	Snoring?			How many? Age stating:
Yes	No	Mouth breathing?	Yes	No	Last infection:
Yes	No	Asthma?	Yes	No	Has your child ever had tubes put in ears?
Yes	No	Allergies? explain:			When? by Dr.
Yes	No	Cry easily?	Yes	No	Are tubes still in place?
Yes	No	Often have temper tantrums?	Yes	No	Has your child seen a neurologist?
Yes	No	Easily angered?			Dr. Date:
Yes	No	Unusual behaviors:	Yes	No	Seizures?

DEVELOPMENT

At about what AGE did your child —

Sit alone age: Crawl age: Walk alone age: Use toilet at age:

Coo and babble? Y / N Age of first word spoken? List first words:

Age using two and three words together? Age using sentences?

Physical Growth: Percentile for height? Percentile for weight?

What hand does your child prefer? Right Left Both

<u>FAMILY HISTORY</u>

		Have any family members (including siblings, cousins, aunts, uncles, etc.) had:	Relationship to your child:
Yes	No	Speech problems or delays?	
Yes	No	Language problems or delays?	
Yes	No	Stutter?	
Yes	No	Receive special education services at school?	
Yes	No	Developmental problems? (i.e. mental challenges, autism, schizophrenia, cerebral palsy)	
Yes	No	Learning problems? (i.e. reading challenges)	
Yes	No	Chronic illness?	
Yes	No	Cleft lip/palate?	
Yes	No	Hearing loss or deafness as a children?	