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?

Tell me about your child's strengths:

Tell me about your concerns:

What have you tried?

Have you observed unusual play, sounds or speech behaviors? Y / N Example:

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

How would you describe your relationship with your child?

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

Child's siblings, parents and any others living in the home, include ages:

Lives in more than one home: Y / N List people in home:

Where is your child during the day?

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

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

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/tablet/hand-held games: a.m. p.m.

Hours of large movement play daily: Hours of quiet time: Nap daily: Y / N From: To:

Child's favorite family activities: Amount of time spent with other children:

BIRTH HISTORY

Born at _____weeks gestation			Yes	No	Surgery?	Yes	No	Breast fed?
Birth weight: _____			Yes	No	Tongue Tie?	Yes	No	Difficulty sucking or feeding?
Yes	No	Was child premature?	Yes	No	Physical or Occupational Therapy?	Yes	No	Colic?
Yes	No	Cesarean?	Yes	No	Saw Neurologist or other specialists?	Yes	No	Vomiting?
Yes	No	Pregnancy complications?			APGAR scores:	Yes	No	GERD (Relux)?
Yes	No	Concerns at birth? Explain:				Yes	No	Low muscle tone?
Yes	No	Did baby stay in the ICU? Length of ICU/hospital stay:						

DEVELOPMENTAL HISTORY

Did your child:			**At about what AGE did your child —**	
Yes	No	Coo and babble?	Sit up alone:	Use two and three words together:
Yes	No	Babble with various sounds?	Crawl:	Use sentences:
Yes	No	Use 3 or fewer consonant by 16 months?	Walk alone:	**Current Physical Growth:**
Yes	No	Have words appear and disappear?	Used toilet:	Percentile for height _____
Yes	No	Difficulty imitating speech?	Speak first word:	Percentile for weight _____

MEDICAL HISTORY

Please list any vitamins or medications your child regularly takes:

Other than at birth, has your child ever stayed in a hospital overnight? Y / N Treated at an emergency room Y / N

Concerns with child's health? Y / N Please explain:

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

Please describe any feeding problems your child has experienced:

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

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

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

FAMILY HISTORY

		Have any family members (including siblings, cousins, aunts, uncles, etc.) had:	Relationship to child:
Yes	No	Speech problems or delays?	
Yes	No	Language problems or delays?	
Yes	No	Stuttering?	
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 in children?	