INTEGRATED CHILDREN'S THERAPIES, INC.

where children make connections

DEVELOPMENTAL SPEECH AND LANGUAGE HISTORY

Parents: This history may appear to be quite long. However, a number of the questions require checking off responses, which can be done quickly. This information is very useful in gaining a clear understanding of your child's strengths and weaknesses. We appreciate your time.

Person Completing History: ☐Mother ☐ Father ☐ Self ☐ Other (specify) _____

General Information:

Child's Full Name:_____ Birth Date:_____

Address:_____ Gender: male_____female_____

_____ Phone #:_____

Child's Race: ☐ Caucasian ☐ African Am. ☐Hispanic ☐Asian ☐Native Am. ☐Other (specify) _____

Is child adopted? ☐Yes ☐No Foster Child? ☐Yes ☐No

Parents are: ☐married ☐separated ☐divorced ☐widowed ☐single ☐other (specify) _____

_____

Parent's Name:_____ Relation to Child:_____

Occupation:_____ Employer:_____

Phone #:_____

Parent's highest education completed: ☐less than high school ☐high school grad ☐some college/associates

☐bachelors ☐ post-graduate ☐doctoral/post-doctoral

Parent's Name:_____ Relation to Child: _____

Occupation:_____ Employer:_____

Phone #:_____

Parent's highest education completed: ☐less than high school ☐high school grad ☐some college/associates

☐bachelors ☐ post-graduate ☐doctoral/post-doctoral

Names and ages of brothers and sisters:_____

Others living in the house (include names and relationship to child/family):_____

_____

Emergency Contact Person:_____

(Name) (Relationship) (Phone #)

Teacher's Name:_____School:_____

Grade in School:_____Type of classroom:_____

Referred by (name, address, profession):_____

Medical Information:

Child's Physician and other Professionals: (continue on back of page if needed)

Physician: _____ Address: _____ Phone: _____

Other: _____ Profession: _____ Phone: _____

Other: _____ Profession: _____ Phone: _____

Other: _____ Profession: _____ Phone: _____

Medical Diagnosis:

_____ ADD/ADHD

_____ Autism

_____ Down Syndrome

_____ Fragile X Syndrome

_____ Tourette's Syndrome

_____ Pervasive Developmental Disorder (PDD)

_____ Other, specify: _____

_____ Anxiety Disorder or Mood Disorder, specify: _____

_____ Cognitive Delay

_____ Emotional Disorder, specify: _____

_____ Learning Disabilities, specify if possible: _____

_____ Non-Verbal Learning Disability

Has child received **previous evaluation** and/or treatment by a Speech and Language Pathologist?_____

If yes, when and where:_____

Has child had a **vision** test?_____ If yes, when?_____

Has child had a **hearing** test?_____ If yes, when?_____

What were the **results** of hearing and vision tests?_____

Has your child had any of the following? If yes, describe and give approximate dates.

Childhood diseases or major illnesses:_____

Congenital abnormalities:_____

Surgery:_____

Serious injury:_____

Casts or braces:_____

Ear infections:_____

Tubes in ears:_____

Allergies:_____

Seizures:_____

Other:_____

List any medications your child is **currently** taking, its purpose and frequency of the dosage:

Medication: _____ Purpose: _____ Freq. of dosage: _____

Medication: _____ Purpose: _____ Freq. of dosage: _____

Medication: _____ Purpose: _____ Freq. of dosage: _____

Medical information continued:

Has your child received medications **in the past** for any of the above-mentioned conditions?

Medication: _____ Purpose: _____ Dates Taken: _____

Medication: _____ Purpose: _____ Dates Taken: _____

Medication: _____ Purpose: _____ Dates Taken: _____

Are there any medical **precautions** the therapist should be aware of when working with your child?

_____

_____

Does your child have any assistive devices (e.g., glasses, casts, wheelchair)?_____

_____

Has your child received other evaluations or treatment (school, psychological, private therapist or clinic, neurology, nutritionist, GI consult, allergist, etc.)? If so, what type, when, and by whom?

Type Eval. Date Professional's Name Dates of therapy

_____

_____

_____

_____

_____

What do you hope to gain from this evaluation and/or treatment?_____

_____

_____

_____

Mother's Health During Pregnancy:

Did the mother:

1) have any infections/illnesses during pregnancy? ☐Yes ☐No

Describe:_____

2) have any shocks or unusual stresses during pregnancy? ☐Yes ☐No

Describe:_____

3) receive any medication during pregnancy? ☐Yes ☐No

If yes, what kind:_____

4) any complications during delivery/labor? ☐Yes ☐No

Describe:_____

Child's Birth:

Was or did child:

1) full term ☐Yes ☐No Weight at birth:

2) premature ☐Yes ☐No Number of weeks:_____

3) breech (feet first) ☐Yes ☐No

4) require forceps for delivery: ☐Yes ☐No

5) require suction for delivery: ☐Yes ☐No

6) have any birth injuries: ☐Yes ☐No

Describe:_____

7) If known, Apgar score at one minute:_____at five minutes:_____

8) require intensive care hospitalization: ☐Yes ☐No

If yes, for how long?_____

9) jaundiced? ☐Yes ☐No Length of treatment_____

Infancy and Early Childhood:

Did your child:

1) have feeding problems? ☐Yes ☐No If yes, describe:_____

_____

2) have sleeping problems? ☐Yes ☐No If yes, describe:_____

_____

3) have colic? ☐Yes ☐No If yes, for how long?_____

_____

4) prefer certain positions as an infant? ☐Yes ☐No If yes, describe:_____

_____

Developmental Milestones:

(Give approximate ages if remembered, or comment on anything unusual)

Said first words_____Said sentences_____

Drink from a cup_____Drink from a straw _____

Are there or have there been any feeding problems (e.g. sucking, swallowing, drooling, chewing, etc) If yes, please describe: _____

_____

Primary language spoken at home:_____

What language is he/she most comfortable speaking/understanding? _____

With whom does he/she spend most of his/her time? _____

Describe your child's speech-language problem:_____

_____

_____

_____

How does your child usually communicate (gesture, words, etc)?_____

_____

_____

When was the problem first noticed? By whom? _____

_____

Has the problem changed since it was first noticed? Explain how: _____

_____

_____

Is your child aware of the problem? How does he/she feel about it? _____

_____

_____

Are there any other speech, language, hearing problem in the family? If yes, please describe: _____

_____

_____

_____

Play Skills:

1) What are your child's favorite play things?_____

_____

2) What does she or he do with these toys?_____

_____

3) Who does child prefer to play with and how does your child interact with others (e.g. shy, aggressive, etc)?___

_____

_____

4) What activities does the child least enjoy?_____

____

5) Are there any things that your child tends to fear or avoid? ☐Yes ☐ No

If yes, describe:_____

6) How long does child play with one toy?_____

7) Does your child tend to play while in one position more than others do? ☐Yes ☐No

If yes, what position?_____

8) Does your child tend to play with things by lining them or piling them up (if over two years of age)?

☐Yes ☐No Describe:_____

9) What extra-curricular activities is your child involved in (i.e., gymnastics, swimming lessons, Scouts, etc.)?

_____

_____

_____

How is your child doing academically/pre-academically? _____

Does your child receive special services? If yes, describe: _____

Please tell us about your child's strengths and gifts: _____

What in particular would you like your child to achieve? _____

How, if in any way, would you like to interact differently with your child? _____

_____ _____

Signature Date

2 Coolidge Street, Hudson, MA 01749 · Main: 978-568-8800 · Fax: 978-568-8877