Family Physician/Pediatrician_____

Physician Phone_____

Name of child's school (if applicable_____)
Has the child had any previous speech/language therapy? Yes No
If yes, when and with whom_____

Is this child receiving speech/language therapy at the present time? Yes No
If yes, with whom?_____

Describe fully the reason(s) for referral_____

II. Developmental & Medical History

Were there illnesses or unusual events that occurred during this pregnancy? Yes No

Was labor and delivery normal? Yes No

During the pregnancy with this child was there:
Anemia Rh Incompatibility Smoking
Diabetes German Measles Alcohol/drugs
Medication (specify)
Injuries (specify)
Was the child full term? Yes No Birth Weight
Problems with: Nursing Sucking Swallowing Drooling
Any problems during the first month? Yes No

To the best of your recollection, at what age was the child able to:
Hold up head while lying on stomach_____

Sit unsupported Walk unassisted_____

Feed self with a spoon Dress self (except tying shoes)_____

At what age was toilet training completed_____

Has the child had any feeding difficulties? Yes No

If yes, please describe_____

What type of cup does your child use?_____

Can he/she drink from a straw? Yes No

If sleep has ever presented a problem, please describe_____

_____

Did child suck thumb or use a pacifier? Yes No

If so, at what age did he/she stop?_____

List any physical limitations the child has_____

Anything in his/her development that concerned you the first 18 months?

_____

II. Developmental & Medical History (

Has the child ever had a hearing evaluation?_____

When?_____

Results?_____

Does he/she understand you when he/she is not watching your face? Yes No

Does child wear glasses? Yes No
If yes, for what reason?_____

Has your child had any hospitalizations? Yes No
If yes, for what?_____

What operations has your child had?_____

_____
Does child have a history of any of the following?

Frequent colds
Ear infection
Asthma

High fevers
Allergies
Were there any after effects from the above illnesses? Yes No
If so, please explain_____

Is the child taking medication? Yes No

If yes, for what reason?_____

III. Speech & Language History

Are you aware of any factors (e.g., physical, emotional, or environmental) that might have contributed to his/her communication difficulty? Yes No
If yes, please describe_____

_____

Please describe any developmental issues in addition to the communication problem your child may have_____

_____

Approximately how many words does your child consistently use?_____

How does your child usually communicate? (check all that apply)
pointing gestures short phrases
sounds single words sentences

Is your child able to understand (check all that apply)
gestures words short phrases sentences

When was the difficulty first noticed_____

Is your child aware of difficulties? Yes No Maybe

Has the difficulty changed since it was first noticed? Yes No
If yes, please describe_____

_____

Does child know there is a problem? Yes No

How does child react?

Does child try to self-correct? Yes No
If yes, how?_____

With whom does the child find it easiest to communicate?_____

Most difficult?_____

At what ages did the child demonstrate the following speech behaviors?

Imitated sounds First words_____

Put 2-3 words together Talked in full sentences_____

Told a simple story accurately_____

IV. Family & Social History

List all people living at home, including relationship to child:
1.
2.
3.
4.

Do any of the above have speech/language difficulties? Yes No
If yes, please describe_____

What is the primary language spoken in the home?_____

Are there other languages spoken in the home? Yes No
If yes, list languages_____

Do any relatives have speech/language difficulties? Yes No
If yes, please describe_____

Does this child have playmates of his/her own age? Yes No

Is your child enrolled in any play groups? Yes No
If yes, what types?_____

Does he/she get along with other children?_____

What are his/her favorite activities or games?_____

Does he/she play contentedly by him/herself?_____

Does he/she prefer to be with children or adults?_____

Please describe your child's personality?_____

What is his/her favorite toy?_____

Any concerns about behavior or social skills?_____

V. School History (If applicable)

At what age did schooling begin?_____

In what grade is the child enrolled?_____

Does child like school? Yes No

What subjects does he/she find difficult?_____
Has the child had problems in school? Yes No
If yes, please describe_____

Thank you very much for taking the time to fill out this lengthy questionnaire. The information you have provided will be extremely useful in helping the clinician evaluate and/or design an intervention program for your child. If there is any additional information you would like to add, please do so below: