

Has your child has/use an/any assistive devices? Yes ___ No ___ If "yes", what type? _____

With whom does your child live? (List in table below)

Name	Age	Gender	Speech Problems? Writing Problems? Fine/ Gross Motor Problems?	Left/Right Handed

COMMUNICATION STATUS

How would you describe the patient's current communication ability? (Check all apply)

___ Almost never communicates ___ Sometimes communicates ___ Communicates frequently

When I know the topic of conversation, my child is:

___ Very easy ___ Fairly easy ___ Difficult for me to understand.

When I don't know the topic of conversation, my child is:

___ Very easy ___ Fairly easy ___ Difficult for me to understand.

In your own words, please describe how your child communicates: _____

What words, if any, does your child say? _____

What words, if any, does your child write? _____

What gestures does your child make (tugging for attention)? When does he/she use these gestures? _____

Briefly describe a typical day for your child: _____

PRENATAL AND BIRTH HISTORY

Check any of the factors below that apply for the patient's birth mother during pregnancy: Gestational age: _____

- | | | |
|------------------------------------|--|---------------------------|
| ___ Excessive Vomiting | ___ Hemorrhaging | ___ X-ray Treatments |
| ___ Illnesses (German measles) | ___ Medications | ___ RH incompatibility |
| ___ Drug Use | ___ Smoking | ___ Previous miscarriages |
| ___ Alcohol Use | ___ Trauma/Injuries | ___ High blood pressure |
| ___ Excessive weight loss | ___ Excessive weight gain | ___ Diabetes |
| ___ Premature rupture of membranes | ___ Need for hospitalization or bed rest | ___ Breech |
| ___ Forceps | ___ Suction | ___ Birth injuries |

Any birthing complications? Please explain: _____

Has your child had any recent surgeries or been hospitalized? Please explain: _____

SPEECH AND LANGUAGE DEVELOPMENT

Indicate when your child first demonstrated the following:

- | Age/Behavior in months | Age/Behavior in months | Age/Behavior in months |
|-----------------------------|--------------------------|---------------------------|
| ___ Cooing, pleasure sounds | ___ Single words | ___ Short sentences |
| ___ Babbling (da-da) | ___ Phrases (more juice) | ___ Jargon (own language) |

What is the primary method(s) your child uses for letting you know what he/she wants?

- | | | |
|------------------------|---------------------------|---------------------------|
| ___ Looking at objects | ___ Pointing at objects | ___ Gestures |
| ___ Crying | ___ Vocalizing/grunting | ___ Sentences |
| ___ Single words | ___ 2-3 word combinations | ___ Physical Manipulation |

Which of the following best describes your child's speech?

- | | |
|---------------------------------------|---|
| ___ Easy to understand | ___ Difficult for parents to understand |
| ___ Almost never understood by others | ___ Difficult for others to understand |

Which of the following statements best describes your child's reaction to his/her speech?

- | | |
|--|---|
| ___ Is easily frustrated when not understood | ___ Has been teased about his/her speech |
| ___ Does not seem aware of speech problem | ___ Tries to say sounds or words more clearly |

Is your child aware of his/her communication difficulties? ___ Yes ___ No How: _____

Does your child have difficulty producing certain sounds? Yes No *Explain:* _____
 Does your child hesitate, repeat, or get stuck on words? Yes No
 Does your child “get stuck” when attempting to say a word? Yes No
 Do you have concerns about your child’s voice? Yes No *Explain:* _____

MOTOR DEVELOPMENT

At approximately what age (*in months*) did your child achieve the following motor milestones?

Age / Milestone	Age / Milestone	Age / Milestone	Age / Milestone	Age / Milestone
<input type="checkbox"/> Head support	<input type="checkbox"/> Reach & grasp	<input type="checkbox"/> Sitting alone	<input type="checkbox"/> Dress Self	<input type="checkbox"/> Rolling over
<input type="checkbox"/> Standing alone	<input type="checkbox"/> Walking alone	<input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Finger foods	<input type="checkbox"/> Crawling
<input type="checkbox"/> Potty trained	<input type="checkbox"/> Undressed self	<input type="checkbox"/> Chewing solid foods	<input type="checkbox"/> Eat with a spoon	

Is your child awkward or clumsy? Yes No

Has your child had any feeding difficulties? Check any item that applies.

<input type="checkbox"/> Sucking or nursing	<input type="checkbox"/> Excessive length of time to drink bottle	<input type="checkbox"/> Thumb sucker
<input type="checkbox"/> Regurgitation of liquids or solids through the nose	<input type="checkbox"/> Difficulty chewing or swallowing meats	<input type="checkbox"/> Use pacifier
<input type="checkbox"/> Chocking and/or gagging	<input type="checkbox"/> Dislikes certain tastes/ textures	<input type="checkbox"/> Drooler
<input type="checkbox"/> Picky eater	<input type="checkbox"/> Difficulty with weight gain	<input type="checkbox"/> Difficulties as a child

Does your child have any toileting problems? Yes No *Explain:* _____

Does your child wet the bed? Yes No

How many bowel movements a week does your child have? _____

Does your child have accidents during the day (wet themselves)? Yes No *Explain:* _____

Check any of these as they apply to your child:	Yes	No	If yes, explain & give ages if possible
Eating Problems			
Sleeping Problems			
Toileting Problems			
Difficulty concentrating			
Needs a lot of structure			
Interactive			
Excitable			
Laughs easily			
Cries a lot			
Difficult to manage			
Overactive			
Sensitive			
Personality problems			
Gets along with others			
Emotional			
Stays with an activity			
Makes friends easily			
Happy			
Irritable			

Which of the following describes the type of play your child likes to engage in the most often?

<input type="checkbox"/> Putting toys in mouth	<input type="checkbox"/> Banging toys together	<input type="checkbox"/> Throwing toys	<input type="checkbox"/> Acting out familiar routines	<input type="checkbox"/> Shaking toys
<input type="checkbox"/> Pushing/pulling toys	<input type="checkbox"/> Make believe play	<input type="checkbox"/> Games with rules	<input type="checkbox"/> Appropriate use of objects	
<input type="checkbox"/> Looking at books	<input type="checkbox"/> Rough & tumble play	<input type="checkbox"/> Role-playing	<input type="checkbox"/> Uses one object for another	

What is the average length of time your child can stay playing one activity? _____

Is your child’s play easily distracted by any of the following?

Nearby activities Other people in the room Auditory stimuli (i.e. voices, the TV) Visual stimuli (i.e. other toys or objects)

Whom does your child prefer to play with? (**Circle all that apply**)

Mother Father Brother/Sister Self Other - Child Other - Adult

SOCIAL/EMOTIONAL DEVELOPMENT

Check behaviors that you feel best describes your child:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Overly active | <input type="checkbox"/> Overly quiet | <input type="checkbox"/> Excessive tantrums | <input type="checkbox"/> Enjoys bouncing |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Very shy | <input type="checkbox"/> Perfectionist | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Friendly, outgoing | <input type="checkbox"/> Imaginative, creative | <input type="checkbox"/> Plays well with other children | <input type="checkbox"/> Dislike lying on back |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Prefers older children | <input type="checkbox"/> Prefers younger children | <input type="checkbox"/> Dislike lying on tummy |
| <input type="checkbox"/> Mouth breather | <input type="checkbox"/> Drooling | <input type="checkbox"/> Easily controlled/Passive | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Dependent on routines | <input type="checkbox"/> Thumb-sucking | <input type="checkbox"/> Interrupted/Unusual sleep pattern | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Interrupted/Unusual eating patterns | | <input type="checkbox"/> Prefers certain positions as an infant | |

Describe any discipline problems you have with your child: _____

Describe any evaluations or therapy for behavior or emotional problems: _____

What method of discipline do you/ spouse use? _____

EDUCATIONAL HISTORY

Educational Setting	Location/School	Teacher(s)	How often (daily, weekly)
Child Care Facility			
Early Childhood Classes			
Birth to 3 Programs			

How many children are in your child's class? _____

What type of classroom is your child in? (i.e. traditional, open classroom, etc...) _____

Does your child exhibit any learning style preferences? Visual Auditory Both

Does your child's developmental performance seem to interfere with his/her school performance? Yes No

Explain: _____

Have teachers expressed any concerns about your child's learning behavior? Yes No Explain: _____

Has your child ever been evaluated for or attended therapy for:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Physical motor problems | <input type="checkbox"/> Other: _____ | | |

Please give locations, dates and results: _____

What other services does your child have now? What has he/she had in the past?

Type of service	Has Now / Location	Had Before / Location / Date
Physical Therapy		
Occupational Therapy		
Speech-Language Therapy		
Psychological or Behavioral Counseling		
Nutritional Services		
Other (describe)		

HEARING HISTORY

Does your child have a history of ear infections or otitis media? Yes No

How many occurrences of ear problems? At what age? _____ Age of onset? _____

What treatments (medications) were prescribed? _____

Has your child ever been treated by an ear, nose, throat specialist? Yes No Who/ When? _____

Do you ever question your child's ability to hear normally? Yes No Explain: _____

When was the last time your child's hearing was checked? Within the last year? 1-3 years ago 4 or more years ago