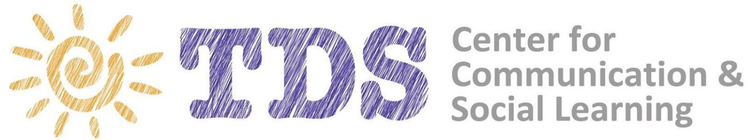

Child Client Family Information/Background History

Date:
Therapist:
Site:

Family Information

Name of Child: Date of Birth:

Age: School Attending: Grade:

Person Completing Form: Relationship to Child:

Address:

Telephone:

Name of Family Members Living at Home:

Language(s) Spoken at Home:

Who is referring your child for a Speech/Language Evaluation:

Why are they being referred:

Medical History

Name of Pediatrician/Specialist currently seeing child:

Were there any problems during pregnancy or during birth? YES / NO

Please explain:

Was your child born before the due date? YES / NO

If so, when:

Has your child been hospitalized at any time? YES / NO

Please explain:

physical address: 462 Main Street, Amherst, MA 01002 • mailing address: P. O. Box 353, Amherst, MA 01004
phone: (413) 835-0735 • fax: (413) 835-0026 • email: tdsamherst@gmail.com • www.tdsspeech.com

Has your child had his/her vision or hearing checked? YES / NO

Results:

Are you concerned about your child's vision? YES / NO

Please explain:

Are there any diagnosed mental, physical or emotional difficulties? YES / NO

Please explain:

Does your child have allergies? YES / NO

If so, what type:

Medications:

Is there a family history of speech and language difficulties? YES / NO

Please explain:

Is there a family history of language learning difficulties? YES / NO

Please explain:

Developmental Milestones

At approximately what age did your child:

Babble: ____________

Use simple words: _____________

Begin combining words: _______________

Walk: ____________

Toilet train: ____________

Oral Motor

Is your child a good eater? YES / NO

Does he/she eat a variety of foods? YES / NO

Does your child have any food aversions or dislike certain textures of food? YES / NO

If so, please describe:

Does your child "overstuff" his/her mouth when eating? YES / NO

Does your child choke or gag when eating? YES / NO

Does your child drool excessively? YES / NO

Does your child have any dental issues (ie rotting teeth, overbite, braces, etc)? YES / NO

Please explain:

Will your child be fitted for braces anytime in the near future? YES / NO

Hearing Status

Does your child:

Answer when you talk to him/her? YES / NO

Talk in a very loud voice? YES / NO

Turn up the volume on the radio or TV? YES / NO

Have an oversensitivity to loud noises? YES / NO

Hear you if his/her back is turned? YES / NO

Hear you if you talk to him/her from another room? YES / NO

Have a history of ear infections? YES / NO

How many: ___________ When was the most recent?:

Does he/she have tubes? YES / NO left ear ____ right ear ____ both ears ____

Has he/she had tubes in the past? YES / NO When:

Do you have any concerns about your child's hearing? YES / NO

Please explain:

Has your child had a hearing test? YES / NO

If yes, where and when:

Results:

Understanding Language

When you talk to your child, how much does he/she understand? Check all that apply:

( ) A few words

( ) Many words or phrases

( ) Simple directions

( ) Multiple directions

( ) Almost everything I say

Additional comments/examples:

Expressive Lanuage

How does your child let you know what he/she wants? Check all that apply:

( ) Cries

( ) Points to what he/she wants

( ) Uses gestures with or without sounds or words

( ) Makes a few sounds

( ) Makes many different sounds

( ) Uses a few words

( ) Says many words, but only one word at a time

( ) Says two or three word sentences

( ) Uses long sentences

( ) Gets frustrated when speaking

( ) Uses echo like speech (repeats exactly what you say)

Additional comments/examples:

Articulation

Do you have to "interpret" your child's speech for others? YES / NO

Can the family understand your child's speech? YES / NO

Can others outside the family understand your child's speech? YES / NO

Does your child get frustrated when he/she is not understood? YES / NO

Are there any specific sounds that your child has difficulty saying? YES / NO

Please list:

Fluency/Voice

Does your child frequently repeat words or parts of words when speaking? YES / NO

Does your child get frustrated when getting "stuck" on a word? YES / NO

Does your child show signs of tension when stuck on a word (ie straining muscles in the neck, eye blinks, etc.) YES / NO

Does your child demonstrate irregular breathing when speaking? YES / NO

Is there a family history of dysfluencies? YES / NO

Please explain:

Does your child have a "different" sounding voice? YES / NO

If so, how would you describe it:

Does your child's voice ever "crack" when speaking? YES / NO

Does your child's voice sound "full"? YES / NO

Does your child have a history of vocal nodules? YES / NO polyps? YES / NO

Does your child clear his/her throat frequently? YES / NO

Pragmatic (Social) Language

Does your child:

- Make eye contact while speaking with others? YES / NO
- Initiate topics of conversation? YES / NO
- Talk about a variety of things? YES / NO
- Maintain conversations with peers? YES / NO with adults? YES / NO
- Enjoy interacting with peers? YES / NO

What does your child like to talk about?:

Previous Therapy/Treatment

My child HAS / HAS NOT been enrolled in therapy/treatment before.

Comments about previous therapy/treatment: (OT/PT/ or Speech)

Is your child still receiving these therapy services? YES / NO

If so, where:

Please comment on the main focus of therapy:

I am concerned about: (Rank the most important to the least important)

1.
2.
3.