



# Santa Rosa Speech & Language Services

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## Child History Questionnaire

Please fill in the following information as completely as possible. This background information will assist us in preparing for the evaluation. Your responses will be treated confidentially.

### 1. Identifying Information

Child's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Sex: Male  or Female

Parent's/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Parents: Together  Separated  Divorced

	Mother	Father
Name		
Age		
Occupation		
Address if different from above		

### Other Children in the Family:

Name	Gender	Age	Grade
	M/F		
	M/F		
	M/F		

Are you currently on disability? Yes  or No

Are you applying for disability? Yes  or No

## 2. Statement of \the Concern

Please describe in your own words what problems your child is having with speech, language, and/or learning:

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When was the problem 1<sup>st</sup> noticed? \_\_\_\_\_

Who noticed the problem? \_\_\_\_\_

What changes in your child's language and/or speech have you noticed since that time? \_\_\_\_\_

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How does your child seem to feel about his or her speaking or hearing ability?

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What reactions do parents, siblings, and/or friends have toward the problem?

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Do you have any thoughts as to the cause of the problem?

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What have you done to try to help your child's problem and has it helped?

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If your child's speech/language/hearing varies, under what circumstances does it become:

A. Better \_\_\_\_\_

B. Worse \_\_\_\_\_

Have you ever sought professional advice about your child's speech/language/hearing problem before? Yes  or No

Was it an evaluation  or therapy ?

Name of Professional or Agency and Address:

\_\_\_\_\_

When? \_\_\_\_\_ How long? \_\_\_\_\_

What recommendations were given?

Check the items that your child seems to do more than other children at the same age:

<input type="checkbox"/>	Avoids speaking at school	<input type="checkbox"/>	Avoids speaking to adults ( <input type="checkbox"/> Male <input type="checkbox"/> Female)
<input type="checkbox"/>	Avoids speaking in play situations	<input type="checkbox"/>	Avoids saying certain words
<input type="checkbox"/>	Avoids speaking at home	<input type="checkbox"/>	Cries when unable to communicate
<input type="checkbox"/>	Avoids speaking to children ( <input type="checkbox"/> Male <input type="checkbox"/> Female )	<input type="checkbox"/>	Becomes aggressive when unable to communicate

Have any relatives had similar problems to that of your child's? Yes  or No

Relationship to child: \_\_\_\_\_ Type of problem: \_\_\_\_\_

### 3. MEDICAL AND DEVELOPMENTAL HISTORY

Medical Diagnosis (if applicable): \_\_\_\_\_

#### MOTHER'S PREGNANCY

Any illness or accidents? Yes  or No

Length of pregnancy: \_\_\_\_\_ Months \_\_\_\_\_ Days

Apgar score (if known): \_\_\_\_\_

Any difficulty at the time of birth? Yes  or No

If yes, please explain \_\_\_\_\_

Is your child: Adopted  or Biological

#### CHILD'S DEVELOPMENT

Age sat alone? \_\_\_\_\_ Age walked alone? \_\_\_\_\_ Age toilet trained? \_\_\_\_\_

Physical Development: Fast  Average  Slow

Coordination: Good  Poor

Check all that apply:

<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Orthodontia	<input type="checkbox"/>	High Fevers
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	Encephalitis
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Eating Problems

	Mouth Breather		Earaches		Eye Problems
	Strep Throat		Adenoidectomy		Heart Problems
	Meningitis		Tonsillectomy		Sleeping Problems

Describe any other illnesses, accidents, injuries, operations, and/or hospitalizations of your child. Include the age of your child at the time of the event.

My child's health is: Good  Fair  Poor

Is your child on any medication or undergoing any medical treatment:

Yes  or No

If yes, please explain \_\_\_\_\_

Please mark all other therapies your child receives:

	Occupational Therapy
	Physical Therapy
	Behavior Therapy
	Speech Therapy
	Other Therapy or Services

If indicated please explain: \_\_\_\_\_

#### 4. SPEECH, LANGUAGE, AND HEARING HISTORY

How old was your child when he/she began:

Babbling: \_\_\_\_\_ First Word: \_\_\_\_\_

What were your child's first words? \_\_\_\_\_

At what age did the child begin using 2 and 3 word sentences? \_\_\_\_\_

Has your child had a hearing screening/evaluation? Yes  date \_\_\_\_\_ or No

What were the results? \_\_\_\_\_

My child talks: Frequently  Occasionally  Rarely/Never

My child prefers to: Talk  Gesture  Both

My child most often uses:

Sounds  Single Words  2-3 Word Sentences  4+ Word Sentences

Does your child:

	Yes	No	If yes, which ones
Use baby signs?			
Make sounds incorrectly?			

Like to read?			If yes, how often
Understand what you say to him/her?			
Have trouble remembering what you say to him/her?			
Scream or yell excessively?			
Read books?			
Hesitate, repeat, or stutter on sounds or words?			

### 5. EDUCATIONAL HISTORY

My child attends: Daycare  Preschool  Pre-K  Kindergarten   
 Elementary School  grade \_\_\_\_ Middle School  grade \_\_\_\_  
 High School  grade \_\_\_\_

School name : \_\_\_\_\_ Regular education  or Special education

My child's work in school is:

Below Average  Average  Above Average

What are your child's best subjects? \_\_\_\_\_

What are your child's worst subjects? \_\_\_\_\_

Does your child receive any special assistance at school? Yes  or No

If yes, please explain \_\_\_\_\_

Has he/she ever repeated a grade? Yes  or No

What is your impression of your child's learning ability? \_\_\_\_\_

### 6. DAILY BEHAVIOR

Check all that apply

<input type="checkbox"/>	Nervous or sensitive	<input type="checkbox"/>	Cries easily	<input type="checkbox"/>	Overactive
<input type="checkbox"/>	Shy	<input type="checkbox"/>	Plays well with others	<input type="checkbox"/>	Underactive
<input type="checkbox"/>	Sleeplessness	<input type="checkbox"/>	Prefers to play alone	<input type="checkbox"/>	Slow learner
<input type="checkbox"/>	Likes school	<input type="checkbox"/>	Has no playmates	<input type="checkbox"/>	Easily Managed
<input type="checkbox"/>	Makes friends easily	<input type="checkbox"/>	Demands excessive attention	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	Needs a lot of discipline	<input type="checkbox"/>	Exceptionally bright	<input type="checkbox"/>	Destructive
<input type="checkbox"/>	Gets along well with other children	<input type="checkbox"/>	Gets along well with adults	<input type="checkbox"/>	Irritable
<input type="checkbox"/>	Difficulty Concentrating	<input type="checkbox"/>	Thumb sucker	<input type="checkbox"/>	Unusual fears

How would you describe your child's personality?

Does your child separate easily from parent? Yes  or No

What games and toys does your child prefer? \_\_\_\_\_

How many hours each day does your child watch television or use electronics? \_\_\_\_\_

Which programs does he/she watch the most? \_\_\_\_\_

### **7. Family**

Who disciplines the child the most? \_\_\_\_\_

What discipline approaches are used? \_\_\_\_\_

Child's reaction to discipline? \_\_\_\_\_

How does your child get along with their siblings? \_\_\_\_\_

Languages spoken at home? \_\_\_\_\_