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:

_____
_____
_____

When was the problem 1st noticed?_____
Who noticed the problem?_____
What changes in your child's language and/or speech have you noticed since that time?_____
_____

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

_____

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

_____
_____

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

_____

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

_____

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:

	Avoids speaking at school		Avoids speaking to adults (☐ Male ☐ Female)
	Avoids speaking in play situations		Avoids saying certain words
	Avoids speaking at home		Cries when unable to communicate
	Avoids speaking to children (☐ Male ☐ Female)		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 DEVOLPMENTAL 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:

	Seizures		Orthodontia		High Fevers
	Fainting Spells		Dental Problems		Encephalitis
	Asthma		Whooping Cough		Headaches
	Allergies		Ear Infections		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 ☐ 2-3Word 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

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