

**Child History Questionnaire**  
**Gresham Speech Therapy**  
**Jill G. Russell, MS, CCC/SLP**

**Confidential:** the information you provide on this form will not be released to parties outside this agency without your consent. Please complete all information requested.

Date completed \_\_\_\_\_ Completed by \_\_\_\_\_

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

How was child referred to this clinic? \_\_\_\_\_

What is your main concern regarding your child at this time? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Other Doctors seen (name and specialty) \_\_\_\_\_

Does your child receive any type of therapy? \_\_\_\_\_ If so, what type, where and when \_\_\_\_\_

\_\_\_\_\_

List other people living in the child's home:

<u>Name</u>	<u>Relationship to Child</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your child adopted?/foster child?/other? \_\_\_\_\_

List any languages your child has been exposed to \_\_\_\_\_

Do any family members or relatives have/had speech, language, voice, stuttering, or learning problems? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

\_\_\_\_\_

## **I. Pregnancy and Birth History**

How was mother's health during pregnancy? \_\_\_\_\_

Any complications, illnesses, and/or accidents? \_\_\_\_\_

Was the baby premature? \_\_\_\_\_ If yes, by how many weeks? \_\_\_\_\_

Baby's weight at birth \_\_\_\_\_

Any complications at birth? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Any complications after birth? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Was child exposed to alcohol or drugs during pregnancy? \_\_\_\_\_

## **II. General Health**

Did the child have any illnesses during early childhood and if so what?

\_\_\_\_\_

Did the child have any physical trauma? \_\_\_\_\_

Psychological Trauma? \_\_\_\_\_

How is your child's general health? \_\_\_\_\_

Any known syndrome or diagnosis? \_\_\_\_\_

Please name any medications your child takes on a regular basis \_\_\_\_\_

\_\_\_\_\_

Does/did your child experience any of the following:

Allergies: \_\_\_\_\_ Meningitis: \_\_\_\_\_

High fever: \_\_\_\_\_ CMV: \_\_\_\_\_

Ear Infections: \_\_\_\_\_

Has your child been hospitalized? \_\_\_\_\_ If yes, for \_\_\_\_\_

\_\_\_\_\_

## **III. Hearing History**

Has your child's hearing been tested? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

By whom? \_\_\_\_\_ Results \_\_\_\_\_

Does your child have a history of ear infections? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

How are your child's ear infections treated? \_\_\_\_\_

Does your child have a history of impacted ear wax? \_\_\_\_\_

Has your child seen an Ear Nose and Throat Doctor? \_\_\_\_\_

Has your child had surgery on his/her ears? \_\_\_\_\_ If so, what kind of surgery and when? \_\_\_\_\_

Does/did your child wear hearing aids? \_\_\_\_\_ If yes, which ear/ears? \_\_\_\_\_

#### **IV. Speech and Language Development**

Give ages when child:

Understood language

Used Language

Knew own name \_\_\_\_\_ Began to make vowel sounds \_\_\_\_\_

Responded to "no" \_\_\_\_\_ Began Babbling ("ba-ba-ba") \_\_\_\_\_

Understood word "bye" \_\_\_\_\_ Began to imitate sounds \_\_\_\_\_

Followed 1 step directions \_\_\_\_\_ Used first words \_\_\_\_\_

Recognized names of familiar objects \_\_\_\_\_ Vocabulary of 10 words \_\_\_\_\_

Pointed to common pictures named \_\_\_\_\_ Vocabulary of 50 words \_\_\_\_\_

Answered "yes" or "no" questions \_\_\_\_\_ Put 2 words together \_\_\_\_\_

How does your child show that he/she understands what you say?

\_\_\_\_\_

Describe how your child lets you know what he/she wants or needs:

\_\_\_\_\_

List three sample sentences, phrases, or words your child now uses:

\_\_\_\_\_

Approximately how much of what your child says do you understand (give percentage) \_\_\_\_\_

Approximately how much of what your child says do unfamiliar listeners understand (percentage)? \_\_\_\_\_

Are sounds omitted? \_\_\_\_\_ Is one sound substituted for another? \_\_\_\_\_ Is the voice unpleasant or different? \_\_\_\_\_

#### **V. Motor Development**

At what age did child sit up? \_\_\_\_\_ Crawl? \_\_\_\_\_ Walk alone? \_\_\_\_\_

Ate solid foods? \_\_\_\_\_ Drank from a cup? \_\_\_\_\_

Dressed self? \_\_\_\_\_ Fed self? \_\_\_\_\_

Was your child breast fed? \_\_\_\_\_ If yes, how long? \_\_\_\_\_ Bottle fed? \_\_\_\_\_

If yes, how long? \_\_\_\_\_

Any problems with breast or bottle feeding? If so, please explain: \_\_\_\_\_

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Please check any feeding difficulties your child has now, or had in the past: \_\_\_\_\_sucking \_\_\_\_\_chewing \_\_\_\_\_choking \_\_\_\_\_swallowing \_\_\_\_\_accepting new foods \_\_\_\_\_strong dislikes for certain foods or textures

Did/does your child suck their thumb, fingers, or pacifier? If yes, please explain when the sucking occurs/occurred and for how long:

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How is the child's overall physical coordination?\_\_\_\_\_

Does the child have any physical handicaps?\_\_\_\_\_

## **VI. Social/Behavioral Development**

Describe your child's favorite play activities\_\_\_\_\_

How does your child interact with others?\_\_\_\_\_

Does the child recognize his/her communication problems?\_\_\_\_\_

When you don't understand the child, what do you do?\_\_\_\_\_

Does/did your child attend Preschool? (where and when)\_\_\_\_\_

Grade School?\_\_\_\_\_Middle/High School?\_\_\_\_\_

Special Services (IFSP/IEP)?\_\_\_\_\_

Is there anything else about your child that is important for us to know?\_\_\_\_\_

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May your child be photographed for therapeutic/insurance reasons?

yes\_\_\_\_\_ no\_\_\_\_\_

Payment: Payment for services is the responsibility of the patient or responsible party.

### **Insurance**

Coverage of speech pathology services varies widely. Some insurance carriers will cover speech therapy for a limited amount of time. Many insurance companies provide coverage for communication disorders associated with illnesses or accidents, but often exclude those disorders that have a developmental etiology. **It is important that you check with your carrier to determine coverage.** If your insurance requires prior authorization or physician referral, it is your responsibility to obtain the necessary documentation and bring it with you to the initial visit.

Be sure to bring your insurance card and any other pertinent information to the initial visit.

