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:

Name	Relationship to Child	Age

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 1step 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:_____

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:

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?_____

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.