



Speech-Language-Hearing History

Client & Family Information:

Child's Name: _____

Mother's Name: _____

Father's Name: _____

Address: _____

Birthdate: _____ Sex: ☐ M ☐ F

Phone: _____ ☐ home ☐ work ☐ cell

Phone: _____ ☐ home ☐ work ☐ cell

E – mail: _____

Doctor's Name: _____

Doctor's Phone: _____

Child lives with (check one):

☐ Birth Parents

☐ Parent & step-parent

☐ Foster Parents

☐ One Parent

☐ Adoptive Parents

☐ Other _____

Other children in family:

Name	Age	Sex	Grade	Speech-language-hearing issues
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What language is spoken in the home?

☐ English only

☐ English & _____

If a second language is spoken in the home:

Who speaks the second language? _____

Which language does the child prefer to use in the home? _____

Does your child ☐ speak ☐ understand the second language

Hearing

Has your child received a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when was it completed? What were the results? _____

Do you feel your child has a hearing problem? ☐ Yes ☐ No



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Hearing (continued)

If yes, please describe. _____

Speech

Has your child received a speech-language evaluation/screening? ☐ Yes ☐ No

If yes, where and when was it completed? What were the results? _____

Do you feel your child has a speech-language problem? ☐ Yes ☐ No

If yes, please describe. _____

Has your child received a speech-language therapy? ☐ Yes ☐ No

If yes, where and when? _____

What was your child working on? _____

Is your child aware of or become frustrated by any speech-language issues? ☐ Yes ☐ No

If yes, please explain. _____

Has your child received any other evaluation and/or therapy (physical, occupational, vision) or counseling? ☐ Yes ☐ No

If yes, please describe. _____

Birth History

How many weeks was the pregnancy? _____

Did the child go home with mother? ☐ Yes ☐ No

If no, how long was the hospitalization and what was the reason? _____

Mother's age at child's birth: _____



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Developmental History

At what age did your child achieve these developmental milestones?

_____ Sat alone
_____ Babbled
_____ Said first word
_____ Walked

_____ Put two words together
_____ Used three word phrases
_____ Toilet trained

Does your child

- Have difficulties chewing or swallowing? ☐ Yes ☐ No
Brush or allow you to brush his/her teeth? ☐ Yes ☐ No
Put toys in his/her mouth? ☐ Yes ☐ No

Medical History

Does your child have any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breathing difficulties | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sleeping difficulties |
| How often? _____ | <input type="checkbox"/> Thumb/finger sucking |
| <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Eyeglasses | |

Other serious injury/surgery: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

If yes, why? _____

Does your child take any medications regularly? ☐ Yes ☐ No

If yes, please list. _____

Pre-School/School Information

List the name of your child's school and grade/level. _____

Teacher's name _____



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Pre-School/School Information (continued)

Does your child have an IEP in place? ☐ Yes ☐ No

If so, what services are received? _____

What school subjects or pre-school activities does your child enjoy? _____

What is your child's current reading level? _____

What school subjects or pre-school activities does your child enjoy? _____

Additional Comments