



**PEDIATRIC SPEECH AND LANGUAGE PATHOLOGY  
HISTORY FORM**

Child's Full Name:		Birth Date:	
Home Phone #:	Work #:	Cell #:	
Address:		Zip Code:	
Insurance Name:		ID #:	
Email address:			
Person Completing Form:		Today's Date:	
Relationship to Child:			
Mothers Name:		Age:	Occupation:
Fathers Name:		Age:	Occupation:
Pediatrician:	Phone #:	Fax #:	
With whom does your child live:			
Siblings (Names and Ages):			
Languages spoken in the home:			
How did you hear about us?			

**Description of the Problem:**

What do you hope to learn from this evaluation?

Please describe your child's speech-language or learning problems:

When did you first become aware of the problem:

How has the problem changed since you first became aware of it:

Are there situations where the problem seems worse and/or better:

**Pregnancy and Birth History:**

Were there any difficulties during pregnancy? Explain:

Length of pregnancy:                      Birth Weight:                      Apgar Score:

Were there any difficulties during labor? Explain:

Were there any feeding, sucking, swallowing, or sleep difficulties during infancy?  
Explain:



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**Medical History:**

Does your child have any medical diagnoses? Please list:

Is your child taking any medications? Which ones and for what?

List any serious illness, surgeries, or accidents with dates:

Did your child have any ear infections as a toddler? If so, how many?

How were the infections treated? (Antibiotics, tube placement, other)

Date and place of your child's most recent hearing test and the results:

Date and place of your child's most recent vision examination and the results:

Are immunizations up-to-date?

**Developmental History – At what age did the following occur:**

Sat alone:

Stood Alone:

Walked unaided:

What hand does the child prefer:

Bowel trained:

Bladder trained:

Babbled(repeated consonant plus vowel production):

First word:

Example:

Estimated current vocabulary size:

Combined two words:

Example:

First sentences:

Example:

Do you have any concerns about your child's feeding or swallowing? If so, please describe:

**Educational History:**

Was your child involved in early intervention or any other early special services? Please list type of services provided and frequency:

Daycare/Play-groups/Preschool attended by your child:

Current school and grade:

Number of children in class:



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**Educational History, continued:**

Do you have any concerns about your child's academic performance? If so, please describe:
Has your child ever received special services in school? Please describe type, frequency and duration:
Has your child had previous speech-language evaluation, therapy or treatment? If so, please describe and include dates:

**Social History:**

Please describe your child's play habits/skills/interests:
Does your child get along with peers? Explain:
Do any immediate or extended family members have a history of speech, language, learning or mental health problems? If so what is their relationship to the child (Uncle, sister, etc.)? What were their difficulties?
Additional information:

\_\_\_\_\_  
**Signature of Parent, Guardian or other Legal Representative**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Printed Name**

