



**CENTER FOR  
SPEECH, LANGUAGE,  
AND LEARNING INC.**

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## CHILD HISTORY FORM

The information you provide us with will help us develop a sense of who your child is and how you, as a parent, experience your child. This helps us to know more about what we need to ask you as well as helps us develop appropriate assessment and intervention plans, as necessary. Thank you for taking the time to be thorough!

Child's Name:		Today's Date:
Date of Birth:	Age:	School District:
School:	Teacher:	

Reason for contacting our office:
Current Diagnoses (of any kind):
Recommendation from other professional(s)/parent(s)? What concerns were shared with you and by whom?

Medical History Prior to Birth	Circle:	Comments:
Were there any illnesses, injuries, surgeries, or prenatal difficulties?	Yes No	
Was delivery: Vaginal Breech Caesarian Other: Please specify		
Were forceps or suctioning used?	Yes No	
What was the child's birth weight?		
Were there any complications following birth? (respiration, transfusions, tube feeding)	Yes No	
Was the newborn hospitalization unusually long? If so, why?	Yes No	
Were there any feeding difficulties as an infant?	Yes No	
Has your child had any significant childhood illnesses? If so, please explain.	Yes No	
Has your child had any significant physical injury? If so, please explain.	Yes No	
Has your child been treated for any physical medical problems? If so, please explain.	Yes No	
Does your child have any allergies, food sensitivities, dietary restrictions? If so, please specify.	Yes No	
Does your child have frequent ear aches or ear infections?	Yes No	
Does your child have PE tubes in his or her ears? If so, have they been replaced?	Yes No	

Does your child seem to hear but not clearly understand what is said to him or her?	Yes	No	
Have you had your child's hearing tested?	Yes	No	
Does your child wear glasses? If so, what is the correction for?	Yes	No	
Is your child currently taking any medications? If so, please list.	Yes	No	
Has your child had their recommended immunizations?	Yes	No	
Has your child had toxicity testing?	Yes	No	
Does your child use any adaptive equipment? If so, what?	Yes	No	
Does your child use any home therapy equipment (trampoline, swing, brushing)? If so, please specify.	Yes	No	
Does your child have sensory needs or sensory defensiveness to touch, sound, texture, odors, or level of stimulation?	Yes	No	

<b>Developmental History</b> <b>At what age did your child do the following milestones?</b>	Approximate age:
Roll over from stomach to back and back to stomach?	
Sit independently?	
Crawl?	
Walk?	
Speak his/her first word? What was it?	
Combine words?	
Speak sentences?	
Drink from a cup independently?	
Feed self with a spoon independently?	
Dress self independently?	
Describe your child at present by circling characteristics that most closely fit him or her:	
Is mostly quiet	Is overly active
	tires easily
	talks constantly
Impulsive	is restless
	is stubborn
	over reacts
Is resistant to change	is usually happy
	fights frequently
	has difficulty separating from primary Caretaker
Is clumsy, describe: _____	
Falls often	wets bed
	is easily frustrated
	has unusual fears
Rocks self frequently	has difficulty learning new tasks (riding a bike, writing)
Has frequent temper tantrums, describe: _____	
Has nervous tics or habits, describe: _____	

<b>Speech and Language History:</b>
Please describe the concerns you have regarding your child's speech and/or language development and give examples if you can.
How does your child make his/her wants and needs known?

Does your child play with toys differently from other children his or her age? Explain.		
Do you have concerns with how your child interacts and communicates socially?	Yes	No
Does your child have special interests that he/she knows a lot about and seems to want to talk about at length often to the exclusion of other topics and without regard to the listener? If so, what is/are the special interest(s)?	Yes	No
Does your child have difficulty understanding nonverbal communication (facial expressions, gestures, physical space, tone of voice) or seem unaware of those communication cues?	Yes	No
If your child is on an IEP, IIP, or IFSP please describe their current speech and language goals.		

<b>Family History</b>		
Does anyone in your family have a history of speech, language, or learning difficulties? If so, please explain who and their relationship to this child.	Yes	No
Is there a family history of related medical diagnoses (physical or emotional)? If so, please explain.	Yes	No

<p><b>Goals:</b></p> <p>I would like to see my child be able to:</p> <p>Examples: <u>speech/language</u> (ex "talk clearly, use more words, follow directions. . .")</p> <p><u>occupational therapy</u> (ex "dress independently, tolerate more sensory experiences, use his/her hands better...")</p>
What does your child like to do?
What does your child dislike?
Has your child received therapy services in the past? If so, where and may we have copies of those reports?

Thank you for your time and attention to this information!