



CENTER FOR  
SPEECH, LANGUAGE,  
AND LEARNING INC.

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Oakdale, MN 55128  
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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:		
Grade:	School Speech Therapist/OT Names:		
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 AND DEVELOPMENTAL HISTORY			
Prenatal and Early History	Circle:	Comments:	
Were there any illnesses, injuries, surgeries, or prenatal difficulties?	Yes No		
Was delivery:	Vaginal Breech Caesarian		
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		
Feeding and Dietary History			
Were there any feeding difficulties as an infant?	Yes No		
Are there currently any feeding difficulties? <i>Avoidance of certain textures, drooling, difficulties with swallowing, chewing, or sucking.</i>	Yes No		
Does your child have any allergies, food sensitivities, dietary restrictions? If so, please specify.	Yes No		
Childhood Medical History			
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 frequent earaches or ear infections?	Yes	No	
Has your child had PE tubes placed in his or her ears? If so, have come out? 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? If yes, please describe the results.	Yes	No	
Has your child had a vision exam?	Yes	No	
Does your child wear glasses? If so, what is the correction for?			
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	

Developmental History	At what age did your child do the following milestones?		
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?			
Does your child use the toilet independently?			
<b>Describe your child at present by circling characteristics that most closely fit him or her:</b>			
<input type="checkbox"/> Mostly Quiet	<input type="checkbox"/> Is Overly Active	<input type="checkbox"/> Falls Often	<input type="checkbox"/> Wets Bed
<input type="checkbox"/> Talks Constantly	<input type="checkbox"/> Tires Easily	<input type="checkbox"/> Is Resistant to Change	<input type="checkbox"/> Has Difficulty Separating from Primary Caretaker
<input type="checkbox"/> Is Usually Happy	<input type="checkbox"/> Is Restless	<input type="checkbox"/> Is Easily Frustrated	<input type="checkbox"/> Has Difficulty Learning New Tasks (riding a bike, writing, Other: _____ )
<input type="checkbox"/> Fights Frequently	<input type="checkbox"/> Is Stubborn	<input type="checkbox"/> Has Unusual Fears	
<input type="checkbox"/> Impulsive	<input type="checkbox"/> Over Reacts	<input type="checkbox"/> Rocks Self Frequently	
Is your child dumsy? Describe: _____			
Has frequent temper tantrums, describe: _____			
Has nervous tics or habits, describe: _____			

**Speech and Language:**

Please describe the concerns you have regarding your child's speech and/or language development and give examples if you can.

When was the problem first noticed and by whom?

Has the problem changed since it was first noticed?

Is your child aware of the problem? If so, how do they feel about it?

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? Explain:	Yes	No
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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
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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
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Is your child is on an IEP, IIP, or IFSP?    Yes    No    If yes, please provide a copy of their most recent IEP/IFSP

**Family History**

Please list the names of siblings and others who live in the home: Individual's Age:

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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
<b>Goals:</b>		
<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. . .")  <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?		

Form completed by: \_\_\_\_\_

**Thank you for your time and attention to this information!**