1128 North Laura Street
Jacksonville, FL 32206
Telephone (904) 355.3403
Fax (904) 355-4149

SPEECH-LANGUAGE PATHOLOGY
Child History Form

Welcome to Jacksonville Speech & Hearing Center (JSHC)! As a part your child's speech and language evaluation the following information is requested. If you are not sure of an answer place a question mark next to the question. Thank you.

Today's Date _____

Person Completing Form _____ Relationship to Child _____

Child's Name _____
Last First Middle

Date of Birth _____ Gender: Male____ Female_____

Address _____
Street Apt #

City _____ State _____County_____ Zip_____

FATHER'S Name _____Date of Birth: _____
(Circle one) Biological Adoptive Guardian Custodial

Education _____ Occupation _____

Place of Employment _____

Telephone #'s Home**:** _____Work:_____Mobile**:**_____

E-mail Address: _____

MOTHER'S Name _____ Date of Birth: _____
(Circle one) Biological Adoptive Guardian Custodial

Education _____ Occupation _____

Place of Employment _____

Telephone #'s Home**:** _____Work:_____Mobile**:**_____

E-mail Address: _____

Child's Pediatrician (PCP) _____

Address _____Telephone _____ Fax _____

Has the child been seen at Jax Speech & Hearing before? Y/N When? _____

Briefly describe your child's problem? _____

_____

When was the problem first noticed? _____

What has previously been done to try and help? _____

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FAMILY HISTORY

It there a family history of any of the following: (Circle all that apply) Asthma Blood Disorders Hearing Loss Psychiatric Disorders Intellectual Disability Substance Use/Abuse Epilepsy Learning Disorder Speech Deficit Language Disorder Stuttering

Other family members in household:

Name	Relationship	Age	Education/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRENATAL & BIRTH HISTORY

How long was pregnancy? ___months Mother's general health during pregnancy? _____

Any problems with pregnancy or delivery? Yes No Emergency C-section? Yes No

Was there premature membrane rupture? Yes No Were forceps/assisted delivery used? Yes No

What was: Birth weight? _____ Apgar Score? _____

Did the infant have any of the following? (Circle all that apply) Breathing problems Oxygen given

NICU stay Jaundice Rubella Antibiotics Heart problem Defect of Ear/Nose/Throat/Mouth

Paralysis Seizures Exposure to Radiation

Any problems with feeding? (Sucking/Swallowing?) Yes No Use of Feeding (NG) tube Yes No

Any other problems/birth defects? Yes No If yes, please describe briefly: _____

HEALTH & DEVELOPMENTAL HISTORY

What was infant's health during first month? Good _____ Fair _____ Poor _____

Has the child had:	Age Started	Description/Comments
Frequent Colds	_____	_____
Ear Infections	_____	_____
Asthma	_____	_____
Vision Problems	_____	_____
Physical Handicap(s)	_____	_____
Epilepsy/Seizures	_____	_____
Attention Deficit Disorder	_____	_____
Traumatic Brain Injury	_____	_____
Drug Allergies	_____	_____

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Is the child currently taking any medications? Yes No
Please list:_____

Has the child had any major surgeries? Yes No
Please list: _____

Has the child had any other serious illness, accident or injury? Yes No
Please list? _____

Did the child meet all developmental stages on time? (ex. Sitting, Crawling, Walking, Feeding Self)? Yes No

If not, please describe: _____
_____

Does the child have/show any of the following behaviors: (Circle all that apply)

Demands attention	Lacks Confidence	Unusual stress at home	Under active
Short attention span	Hyperactive	Easily managed at home	Impulsive
Nervous or sensitive	Withdrawn	Confused in noisy places	Daydreams
Easily frustrated	Tires easily	Talks excessively	Poor eater
Profits from discipline	Aggressive	Lacks motivation	Easily Distracted
Overly sensitive to loud noises	Prefers to play alone	Difficulty following directions	
Plays well with playmates	Makes inappropriate statements		

Other: _____

SPEECH & HEARING HISTORY

Has the child had ear infections/ear aches/ear abscesses?	Yes	No
Do you suspect or ever suspected a hearing loss in the child?	Yes	No
Has the child ever complained about noise in his/her ears?	Yes	No
Has the child ever been exposed to loud noises/explosions?	Yes	No
Does the child presently wear a hearing aid?	Yes	No
Did the child babble of make cooing sounds as an infant?	Yes	No
Did the child stop babbling before expected to at any time?	Yes	No
Does the child try to imitate speech?	Yes	No
Are words used meaningfully?	Yes	No

Age when first word was used _____ About how many words does child say now? _____

Does the child combine two or more words together (such as “Want drink” or “Mommy car”? Yes No

Please give an example: _____
_____

Does the child use sentences? Yes No Average length of sentences (# of words): _____

Who is able to understand the child? _____

What has been done at home to help correct the problem?_____

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EDUCATIONAL & SOCIAL INFORMATION

School presently attending: _____

Teacher's Name: _____ Any additional services child receives at school_____

Grade level _____ Any grade(s) repeated? Yes No Which grade? _____

Any grade(s) skipped? Yes No Which grade? _____

What are his/her grades in:

Reading _____ Math _____ Spelling _____

Science _____ Geography/Social Studies/History _____

Did the child receive a speech/language screening at his/her school? _____

How does the child feel about school and his/her teachers? _____

Does the child have serious difficulty in any subject/activity? Yes No If yes, what subject?

_____

Does the child excel in any particular subject/activity? Yes No If yes, what subject?

_____

Has the child ever had an intelligence test? Yes No If yes, what were the results?

_____

Are there behavioral/discipline difficulties? Yes No If yes, in what way?

_____

ADDITIONAL COMMENTS/OTHER IMPORTANT INFORMATION

Is there any other information you feel would help us evaluate your child? _____

_____

_____

Are there any questions you would like to ask us? _____

_____

_____

Signature of PARENT/GUARDIAN: _____ DATE:_____

Relationship to Child: _____