



4. At what age did the child first use:  
\_\_\_\_\_ real words (hi, cookie, juice)  
\_\_\_\_\_ two word combinations (bye-bye Daddy)  
\_\_\_\_\_ short sentences (gimme more of that)

5. Family history of speech, hearing or learning problems? (check) \_\_\_\_\_ Yes \_\_\_\_\_ No

6. Is there a language other than English spoken in the home on a regular basis? (This includes American Sign Language.) If yes, please describe and give frequency of use:

**HEARING:**

1. Describes any concerns about hearing: \_\_\_\_\_

2. Has the child's hearing been tested? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, when was the testing done, who did it, and what were the results?  
When: \_\_\_\_\_ Who: \_\_\_\_\_  
Results: \_\_\_\_\_

3. The child's hearing seems better in the : \_\_\_\_\_ left ear \_\_\_\_\_ right ear \_\_\_\_\_ both the same

4. The child's hearing seems to be:  
\_\_\_\_\_ normal  
\_\_\_\_\_ normal, but doesn't understand what is heard  
\_\_\_\_\_ poor only when the child is congested or has an ear infection  
\_\_\_\_\_ poor all the time

5. Check all statements which apply to the child's hearing:
- \_\_\_\_\_ Child wears a hearing aid
  - \_\_\_\_\_ Has no difficulty hearing
  - \_\_\_\_\_ Child doesn't always answer when called from another room
  - \_\_\_\_\_ Doesn't always look to find sounds such as a telephone, siren, doorbell, or voice
  - \_\_\_\_\_ Child hears a loud voice much better
  - \_\_\_\_\_ Can hear better if the child watches your face
  - \_\_\_\_\_ Insists on having the TV turned up loud
  - \_\_\_\_\_ Child's teacher says that s/he has trouble following verbal directions
  - \_\_\_\_\_ Child frequently says "Huh?" or "What?"

6. Does anyone related to the child have a permanent hearing loss which began in childhood or early adulthood? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain: \_\_\_\_\_

**BIRTH INFORMATION:**

1. Describe mother's general health during pregnancy \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Describe mother's illnesses, accidents, or difficulties during pregnancy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Medications/alcohol/drugs used during pregnancy, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. How long was the pregnancy? \_\_\_\_\_ Baby's birth weight: \_\_\_\_\_
5. Did the child/mother experience any of the following during labor and delivery or after delivery? (Check all that apply.)

- |                                |                                       |
|--------------------------------|---------------------------------------|
| _____ difficult/long labor     | _____ Rh problems                     |
| _____ Cesarean section         | _____ seizures                        |
| _____ evidence of birth injury | _____ jaundice (yellowish skin color) |
| _____ birth defects            | _____ cyanosis (bluish skin color)    |
| _____ difficulty breathing     | _____ infection                       |
| _____ intensive care nursery   | _____ Other _____                     |

How was this taken care of? \_\_\_\_\_

**DEVELOPMENTAL HISTORY:**

1. At what age did the child:  
sit alone? \_\_\_\_\_ walk alone? \_\_\_\_\_ complete toilet training? \_\_\_\_\_
2. Overall development seems to be:  
\_\_\_\_\_ somewhat faster than most children. In what areas? \_\_\_\_\_ about t  
\_\_\_\_\_ somewhat slower than most children. In what areas? \_\_\_\_\_  
\_\_\_\_\_

3. Which of the following describe the child's coordination? (Answer only if two years or older.)

Check all that apply:

- Has no difficulty with general coordination
- Has difficulty getting on/off chairs or vehicle toys
- Frequently stumbles when waling or jumping
- Has difficulty maintaining balance when sitting, walking, jumping or bending over  
(underline area of difficulty)
- Has trouble catching and throwing a ball
- Seems clumsier than most children
- Has difficulty working with small objects such as puzzles
- Other concerns (please describe)

4. Which of the following describes what your child can do? (Answer only if child is age 5 or under)

Most often uses the following when eating:

- cup       fork       spoon       fingers       bottle

other: Describe \_\_\_\_\_

Child can do the following:

- |  |  |
|--|--|
| <input type="checkbox"/> dress himself/herself | <input type="checkbox"/> wash face & hands |
| <input type="checkbox"/> undress               | <input type="checkbox"/> bathe             |
| <input type="checkbox"/> brushes hair          | <input type="checkbox"/> brushes teeth     |
| <input type="checkbox"/> button                | <input type="checkbox"/> tie shoes         |

**BEHAVIOR**

1. How would you describe the child's personality? \_\_\_\_\_

2. The child has problems in these areas: (check all statements that apply)

- Most often ignores others
- Frequent temper tantrums
- Often fights with other children
- Hard to discipline
- Difficulty concentrating or staying with one activity
- Often breaks or destroys things
- Constantly demands adult attention
- Difficulty separating from mother
- Easily frustrated
- Short attention span
- Other: \_\_\_\_\_

3. a) How is the child disciplined? \_\_\_\_\_  
 \_\_\_\_\_

b.) Are these methods effective? \_\_\_\_\_  
 \_\_\_\_\_

4. In your opinion, does the child appear to have an unusually high activity level?  
 \_\_\_ Yes \_\_\_ No

Explain/describe \_\_\_\_\_

<b>MEDICAL INFORMATION</b>
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**GENERAL HEALTH**

1. Describe general health of the child: \_\_\_\_\_

2. What medication(s) is the child presently taking? \_\_\_\_\_  
 \_\_\_\_\_ For how long? \_\_\_\_\_

3. Has the child had any of the following? (Check all statements that apply)

Check	Age		Check	Age	
_____	_____	failure to thrive	_____	_____	chicken pox
_____	_____	mumps	_____	_____	high fever
_____	_____	scarlet fever	_____	_____	seizures
_____	_____	measles -10 or 3 days	_____	_____	frequent colds
_____	_____	pneumonia	_____	_____	tonsils removed
_____	_____	meningitis	_____	_____	adenoids removed
_____	_____	head injuries	_____	_____	operations
_____	_____	allergies	_____	_____	Other: _____
_____	_____	asthma			

Comments: \_\_\_\_\_  
 \_\_\_\_\_

4. Describe any other serious illnesses, injuries, operations or physical problems and treatment  
 \_\_\_\_\_

5. Has your child been immunized for:

Yes	No		Yes	No	
_____	_____	poliomyelitis	_____	_____	mumps
_____	_____	measles	_____	_____	diphtheria
_____	_____	rubella			

**EARS:**

1. How many ear infections has the child had? \_\_\_\_\_  
When was the first? \_\_\_\_\_ Most recent? \_\_\_\_\_  
What type of treatment was given? \_\_\_\_\_ By which doctor? \_\_\_\_\_

2. Check any problems with the child's ears, past and present:

- \_\_\_\_\_ fluid present in ears. When? \_\_\_\_\_
- \_\_\_\_\_ excessive wax
- \_\_\_\_\_ drainage from ears
- \_\_\_\_\_ tubes in ears; when inserted: \_\_\_\_\_
- \_\_\_\_\_ earaches
- \_\_\_\_\_ other: \_\_\_\_\_

**VISION:**

1. Are there concerns about the child's sight? \_\_\_\_\_
2. Has vision been tested? \_\_\_\_\_ Where? \_\_\_\_\_  
When? \_\_\_\_\_ Results? \_\_\_\_\_

**DENTAL HEALTH:**

1. Are there concerns about the child's teeth or mouth? \_\_\_\_\_  
Describe: \_\_\_\_\_
2. Dentist's name: \_\_\_\_\_

**EDUCATIONAL INFORMATION:**

1. Present School/Daycare: \_\_\_\_\_ Grade? \_\_\_\_\_  
School District: \_\_\_\_\_
2. Has the child repeated any grades? \_\_\_ Yes \_\_\_ No Which one(s)? \_\_\_\_\_
3. How well does the child do in school? \_\_\_ good \_\_\_ average \_\_\_ poor
4. If the child is not doing well in school, please describe: \_\_\_\_\_  
\_\_\_\_\_

**SPECIAL SERVICES**

Describe any special testing, treatment or therapy the child has had in the past or is currently receiving. (Examples: speech, psychological, developmental, neurological)

Type of Service: \_\_\_\_\_ Type of Service: \_\_\_\_\_

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

Location: \_\_\_\_\_ Location: \_\_\_\_\_

Results: \_\_\_\_\_ Results: \_\_\_\_\_

Treatment: \_\_\_\_\_ Treatment: \_\_\_\_\_

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**PERSONS LIVING IN HOUSEHOLD:**

NAME	AGE	RELATIONSHIP TO CHILD
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

**PLEASE SIGN ATTACHED RELEASE FORM**