

Statement of The Problem

Describe the problem: _____

When was the problem first noticed: _____

Describe how you and others in the family react to this problem _____

What do you think causes this problem: _____

Describe what has been done about it- when and were: _____

General Development

PREGNANCY

Mother's state of health: _____

Length of pregnancy: _____ Medications Taken: _____

Difficulties during pregnancies: _____

Miscarriages or stillborns: _____ Number of living children: _____

DELIVERY

Hours of labor: _____ Was labor induced _____

Complications: _____

Type of Delivery:

Normal: _____ Instrument: _____ Breech: _____ Caesarean: _____

Drugs or Anesthesia used: _____

Single or Multiple Birth: _____

CONDITION AT BIRTH

Full term: _____ Premature: _____ Jaundiced: _____ Bleeding: _____ RH Factor _____ Breathing

Difficulties: _____

Birth Weight: _____ Length: _____ Age at discharge from nursery _____

Evidence of birth injury: _____

Congenital Birth Defects: _____

Health during first weeks of life: _____

Comments: _____

DEVELOPMENTAL

AT what age did the child:

Sit alone: _____ Crawl: _____ Stand alone: _____ Walk: _____

Feed Self: _____ Drink from a cup: _____ Bowel control: _____

Bladder control: _____ Dress self: _____

Was the child bottle or breast fed: _____ Age when weaned: _____

Any feeding problems: _____
Does the child choke while eating: _____
On what foods: _____
Does the child suck his/her thumb: _____
Does the child trip or stumble often: _____
Does the child drool: _____

MEDICAL HISTORY

Describe any unusual diseases or surgery: _____

Describe any serious illnesses, accidents, or high fevers: _____

Earaches or ear infections: _____

Does the child have frequent coughs, colds, sinus congestion, and/or respiratory infections: _____

List any medication the child is currently taking and why: _____

Name of any doctor involved if other than listed on page 1: _____

List of any known allergies and to what: _____

Have ears been tested: _____ When: _____ By whom: _____

Results: _____

Do you think the child hears adequately: _____

Does the child's hearing appear constant or variable: _____

Does the child's hearing worsen when he/she has a cold: _____

PREVIOUS EVALUATIONS AND/OR TREATMENT

Has the child ever been evaluated and/or treated for hearing, vision, speech-language motor, seizure, behavior, emotional, or learning problems: _____

Dates: _____ By whom: _____

Type of evaluation and/or treatment: _____

Results and/or recommendations: _____

SPEECH-LANGUAGE HISTORY

Did the child make babbling and cooing sounds during first six months: _____

Age at which the child spoke single words: _____

Two word phrases: _____: spoke so the family could understand him/her _____

Age at which a speech-language problem was first suspected: _____

Does the child follow simple directions such as "get me the ball": _____

Is the child aware of the problem: _____

Does the child's speech pattern cause him/her to be shy, withdrawn or maladjusted: _____

Are there any known defects of the child's tongue, palate, nose, throat, ears, lips, or teeth: _____

Are there any family members with speech, language, or hearing problems: _____

What is the primary language spoken in the home: _____

Any other languages spoken in the home: _____

Does the child enjoy speaking: _____

Does the child enjoy playing with other children: _____

This form was completed by: _____

Relationship to patient: _____