



RACHEL CORTESE
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 SPEECH LANGUAGE PATHOLOGIST
 BOARD CERTIFIED BEHAVIOR ANALYST

SPEECH LANGUAGE HISTORY
 &
 BACKGROUND INFORMATION

(Please Print)

Today's date:	Name of person completing form:
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IDENTIFYING INFORMATION

Child's last name:	First:	Birth date:	Age:	Sex:
				<input type="checkbox"/> M <input type="checkbox"/> F
Street address:	City:	Zip:	Mother's cell phone:	Father's cell phone:

FAMILY INFORMATION

Mother's name:	Father's name:	Mother's Occupation:	Father's Occupation:
Mother's email address:	Father's email address:	Parent's marital status (check one)	
		Single <input type="checkbox"/> / Mar <input type="checkbox"/> / Div <input type="checkbox"/> / Sep <input type="checkbox"/> / Wid <input type="checkbox"/>	

Does your child receive care from a babysitter/nanny at home?

<input type="checkbox"/> Yes <input type="checkbox"/> No	Name:	Hours:

Who lives at home with your child?	With whom does your child spend most of his/her time outside of school/nursery/daycare?	Names of Siblings:	Age:
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Babysitter <input type="checkbox"/> Siblings <input type="checkbox"/> Other	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Babysitter <input type="checkbox"/> Siblings <input type="checkbox"/> Other		

Is there a language other than English spoken in the home?	If yes, which one?
<input type="checkbox"/> Yes <input type="checkbox"/> No	

(OVER)

Who in the family speaks the language?	Does your child speak the language?	Does your child understand the language?	If your child has any words, which language does your child prefer to speak at home?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does anyone in the family have a history of:			
<input type="checkbox"/> Learning problems <input type="checkbox"/> Behavior problems <input type="checkbox"/> Speech/Language difficulties <input type="checkbox"/> Stuttering <input type="checkbox"/> Autism		<input type="checkbox"/> Anxiety or Depression <input type="checkbox"/> Selective Mutism (refusal to speak) <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Blindness <input type="checkbox"/> Tics	
If you answered yes for any of the above, please explain:			

MEDICAL HISTORY				
Primary care doctor:	Doctor's phone number:			
Does your child have any allergies?	Medication History:			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Medication	Dates	Reason for Medication	Benefits and side effects
Has your child ever been diagnosed with any of the following?				
<input type="checkbox"/> Learning problems <input type="checkbox"/> Behavior problems <input type="checkbox"/> Speech/Language difficulties <input type="checkbox"/> Stuttering <input type="checkbox"/> Autism <input type="checkbox"/> Selective Mutism (refusal to speak)		<input type="checkbox"/> Anxiety or Depression <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Blindness <input type="checkbox"/> Tics <input type="checkbox"/> Reflux		
If you answered yes for any of the above, please explain:				

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Has your child ever sustained a head trauma/injury?
<input type="checkbox"/> Yes <input type="checkbox"/> No

HEARING HISTORY		
Have there ever been any hearing concerns?	Has your child had any ear infections/ congestion requiring medication or tubes?	If you answered yes to either of the previous questions, please describe:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
When was your child's last hearing test?	Where were these tests done?	What were the results?

DEVELOPMENTAL HISTORY		
Duration of Pregnancy (in weeks):	Were there any prenatal complications or complications during delivery? If yes, please explain:	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Developmental Milestones: Please list the approximate age at which your child accomplished each milestone.		
Skill	Age	Comments/Concerns
Sat without help		
Crawled		
Walked		
Started babbling		
Used first words		
Named objects		
Put two words together		
Have there been any concerns about your child's growth or development? Please explain.		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Has your child lost any skills or abilities? Please explain.
<input type="checkbox"/> Yes <input type="checkbox"/> No

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Do you have any concerns about your child's sleep? If yes, please explain.

Yes No

EDUCATION HISTORY

Does your child currently attend nursery, daycare or school?

<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where?	Address of nursery/daycare/school:	Phone number of nursery/daycare/school:

What is the age level/grade of the class?	Type of Program:	Attends how many days/week?	Hours?
	<input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Special Ed <input type="checkbox"/> Regular Ed		

If applicable, please check boxes next to special services that your child receives *in school, during the school day*:

<input type="checkbox"/> Resource Room <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Counseling <input type="checkbox"/> Adaptive Physical Education	<input type="checkbox"/> Speech/Language Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> 1:1 Para <input type="checkbox"/> Other _____
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Please list all previous daycares, preschools and schools your child attended:

School Name	Dates	Comments?

Has your child ever repeated a grade?

Yes No

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EVALUATION & TREATMENT HISTORY

Please list all previous <i>speech and language evaluations</i>	Please list all <i>other</i> previous evaluations (e.g. physical therapy, counseling, occupational therapy, vision, hearing, special education, neurological etc.)
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Agency/ Hospital/ Clinician, etc.	Date:	Type of Evaluation:	Date:

Has your child ever had speech therapy?	If yes, where and when?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?

Has your child ever had any other therapy or intervention (e.g. physical therapy, counseling, occupational therapy, vision, hearing, special education)?	If yes, where and when?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	When?

Is your child *currently* receiving any special services outside of school? Please check all that apply:

<input type="checkbox"/> Speech <input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Counseling	<input type="checkbox"/> Audiology <input type="checkbox"/> Behavioral Therapist or ABA	<input type="checkbox"/> Special Education <input type="checkbox"/> Tutoring
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CURRENT COMMUNICATION PROFILE

Describe your main concern about your child's speech and/or language:

When was the problem first noticed? By whom?	Has it changed at all since first noticed? Please explain.
	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Is the child aware of the problem?	If yes, how does he or she feel about it? (e.g. frustrated/ doesn't seem bothered?)
<input type="checkbox"/> Yes <input type="checkbox"/> No	
In what ways does your child currently communicate (check all that apply):	
<input type="checkbox"/> Eye contact <input type="checkbox"/> Body movements <input type="checkbox"/> Making sounds (e.g. babbling) <input type="checkbox"/> Gestures (e.g. pointing, showing, gesturing "up") <input type="checkbox"/> Making sounds in combination with pointing? <input type="checkbox"/> Using signs/pictures	<input type="checkbox"/> Using sounds that stand for words (e.g., "brmm" referring to car) <input type="checkbox"/> Word approximations <input type="checkbox"/> Short phrases (two words or more, e.g. "more juice," "mommy go") <input type="checkbox"/> Phrases of three words (e.g., "me more cookies") <input type="checkbox"/> Short sentences (e.g. "I want more cookies") <input type="checkbox"/> Conversation (talks back and forth with you)
Does your child (check all that apply)...	
<input type="checkbox"/> Repeat sounds, words or phrases over and over? <input type="checkbox"/> Seem to understand what you are saying? <input type="checkbox"/> Retrieve/point to common objects upon request (ball, cup, shoe)?	<input type="checkbox"/> Follow simple directions ("Shut the door" or "Get your shoes")? <input type="checkbox"/> Respond correctly to yes/no questions? <input type="checkbox"/> Respond correctly to who/what/where/when/why questions?
Does your child show interest in the people and things around him/her?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
How does your child interact with others?	
<input type="checkbox"/> Shy <input type="checkbox"/> Cooperative <input type="checkbox"/> Aggressive <input type="checkbox"/> Uncooperative	<input type="checkbox"/> Plays alongside but quietly <input type="checkbox"/> Watches other children <input type="checkbox"/> Mainly grabs things <input type="checkbox"/> Other _____
How does your child usually let you know what he/she wants?	
Does your child have any behavioral difficulties (e.g. tantrums, aggressive behavior, extreme shyness, etc.)? If yes, please explain:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child have a history of drooling or feeding problems (e.g. difficulty chewing, swallowing, biting or keeping saliva in his/her mouth)? If yes, please explain:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Does your child have difficulty saying certain sounds? If yes, please describe:
<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or anyone else outside the home have trouble understanding what your child is saying?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
If your child is talking, does your child stutter, or repeat sounds and words? If yes, please explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have concerns about your child's ability to understand vocabulary, answer questions or follow directions? If yes, please explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child demonstrate any pre-academic skills (i.e. does he/she know any colors, letters, songs, orient to a book, etc.)?
<input type="checkbox"/> Yes <input type="checkbox"/> No

MISCELLANEOUS
What types of activities does your child enjoy?
Does your child participate in any classes, groups, teams or organizations or take any lessons outside of daycare/nursery/school?

OPTIONAL
Please feel free to use this space to provide us with additional information about particular life events or circumstances that you feel have had a significant impact on your child's communication, development and/or your family.

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IN CASE OF EMERGENCY		
Name of local friend or relative (not living at same address):	Relationship to patient:	Phone no.:

Please provide copies of any previous evaluations, and if your child is currently receiving any support services, please provide a recent progress report or copy of their most recent IEP.

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