Articulate Speech and Language Therapy, LLC
4325 Laurel Street, Suite 100
Phone: 907-569-5665 Fax: 866-839-0425

Child History Form

Today's Date ___________ Client Name: ________________________________

Date of Birth: _______________ Age: __________ ☐ Male ☐ Female

Person completing form: ____
Referring Physician: ____

Family Background
Caregiver 1 Name: ____
Occupation: ____
Caregiver 2 Name: ____
Occupation: ____

Which caregivers does the child live with? Check all that apply:

☐Birth Parent(s) ☐Adoptive Parent(s) ☐Foster Parent(s)

☐Grandparent(s) ☐Both Parents ☐Parent 1 Only

☐Parent 2 Only ☐Other: _______________________________________

Does the child have siblings? Please provide names and ages:
____

____

Language(s) are spoken in the home: _____________________________________

Is there anything additional you would like to share about your family / home environment?
____

Medical History:

1. How many weeks gestation was the child born? ____weeks (40 weeks is typical)
2. The child was _____ lbs ____oz and ________ inches at birth
3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section
4. Please describe any complications or concerns during pregnancy, labor or delivery:
____

Has your child experienced any of the following: Check and describe all that apply:

☐ Adenoidectomy ☐ Asthma ☐ **Allergies**__________________
☐ Brain injury ☐ Breathing problems ☐ Behavior problems
☐ Diabetes ☐ Drug/Alcohol exposure ☐ Ear infections
☐ Ear tubes ☐ Encephalitis ☐ Frequent colds
☐ Hearing challenges ☐ High fevers ☐ Measles
☐ Meningitis ☐ Mumps ☐ Seizures
☐ Sensory issues ☐ Sleep issues ☐ Tongue tie
☐ Tonsillectomy ☐ Vision issues ☐ Other______________________

Medical diagnoses:____
Current medications: ____

Surgeries/hospitalizations: ☐ Yes ☐ No
Please describe: ____

Assistive technology? (communication device, hearing aids, etc.) ☐ Yes ☐ No
Please describe:____

Is the child currently receiving any of the following services privately or through the school district? If yes, please list the person's name, last date of service and contact information, if available.

☐Developmental Pediatrician ____
☐Neurologist ____
☐PT ____
☐OT ____
☐SLP ____
☐Behavioral Therapist ____
☐Educational Consultant ____
☐Psychologist / Psychologist ____
☐Other: ____

Evaluation

Briefly describe why you're seeking a speech/language evaluation at this time:
____
____
____

Has the child had a previous speech, language or feeding evaluation / treatment?
☐Yes ☐No By whom: ________________________When: ______________
Describe the results: ____
____

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If you have copies of these, please provide them for review. Thank you!

Developmental History

At what age did your child do the following:

Sit alone: _____ Crawl: ______Stand: _____ Walk _____
Feed self:_____ Babble:_____ Speak 1 word: _____
Combine words: _______ Speak in sentences: _____

How does your child communicate?

☐ behaviors/actions ☐gestures ☐signs ☐single words ☐brief phrases

☐sentences/conversation ☐communication device/other_____________

What percentage of your child's speech do you/family members understand? _______%
What percentage of your child's speech do less familiar people understand? _____%

Does your child experience frustration when not understood? ☐Yes ☐No

Does your child have any difficulty with the following:

☐Attention ☐ Anger/aggression

☐Sleeping ☐ Excessive drooling

☐Feeding/swallowing ☐Limited diet/picky eating

☐Sensitivity to noise ☐Maintaining eye contact

☐Producing speech sounds ☐ Answering questions

☐Understanding people ☐ Following directions

☐Stuttering ☐Using vocabulary or grammar

☐Trouble making/keeping friends ☐Participating in conversation

☐Remembering ☐Transitioning between activities or settings

☐Other difficulties: ____

Educational History

Is the child currently enrolled in daycare/school: ☐ Yes ☐ No
School/Center Name: __________________________ Grade: _____________

What day(s)/times do they attend? ____

Please describe any educational difficulties or learning challenges your child experiences:
____
____

If he/she is on an Individual Educational Plan (IEP) or receive any accommodations/supports, please describe:

____
____

Social History

Describe how the child interacts with parents, siblings, or other family members:

____

____

What are your child's strengths/interests? ____

____

What are your child's favorite activities? ____

____

Does your child become easily frustrated with certain activities? If so, please explain:

____

____

Describe how your child interacts with other children:

____

____

Describe your goals for your child over the next 6 months:

____

____