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Pediatric History Questionnaire

Today's Date: _____

Client's Name_____**DOB**_____ **Age**_____

Address_____**City**_____**Zip** _____

Parent's name_____**Phone#** _____

Parent's name_____**Phone#** _____

E-Mail address _____

Siblings? Y / N

Name_____ Age____ Name_____ Age____
Name_____ Age____ Name_____ Age____
Name_____ Age____ Name_____ Age____

Are both parents in the home? Y / N **Child's primary language** _____

Other languages spoken by child _____ **% Spoken** _____

Other languages spoken in home _____ **% Spoken** _____

Pediatrician Name_____ **Who Referred You?**_____

Any Preschool Experience? Y / N **Where** _____
Dates Attended _____
Reason for today's visit _____
_____
_____
Any Previous Diagnosis_____
Previous Evaluation? Y / N **Where**? _____**Date(s)** _____
Results of Evaluation _____
Speech Therapy? Y / N **Where**? _____**Date(s)** _____
Occupational Therapy? Y / N **Where**? _____**Date(s)** _____
Physical Therapy? Y / N **Where**? _____**Date(s)** _____
Behavioral Therapy? Y / N **Where**? _____**Date(s)** _____

HEALTH HISTORY

Any difficulties during pregnancy _____

Was child full term? Y / N **# Weeks Premature**_____

Any difficulties at birth?_____

Does your child have a history of frequent ear infections? Y / N **Age(s)** _____

Date of last hearing evaluation (please check one):

- ❒ Screening _____ Pass _____ Fail _____
- ❒ Test _____ Pass _____ Fail _____
- ❒ Does your child currently have tubes? Y / N
- ❒ Has your child ever had tubes? Y / N Date: _____

Date of last vision evaluation (please check one):

- ❒ Screening_____ Pass _____ Fail _____
- ❒ Test _____ Pass _____ Fail _____

Any other health problems _____

Current Medication(s) _____

Allergies _____ **Special Diet** _____

DEVELOPMENTAL HISTORY:

Age when child:

First babbled_____ Two words together _____
First Words_____ Used short sentences _____

Has your child used:*(circle all that apply)*

Pacifier bottle "sippy" cup thumb-sucking If so, until what age?_____

Have other family members had speech/language problems? Y / N

Explain_____

_____

_____

Who best understands your child? _____

In your opinion, what percentage of your child's speech is understood by the average listener? _____ %

SPEAKING SITUATIONS

Place a check in the appropriate box that best describe your child in speaking situations with each type of listener:

		Family Members	Other Adults	Other Children
Frustration:				
	Little or None	☐	☐	☐
	Some	☐	☐	☐
	Much	☐	☐	☐
Willingness to Repeat:				
	Little or None	☐	☐	☐
	Some	☐	☐	☐
	Much	☐	☐	☐

Does your child avoid social situations because of his speech/language problems? Y / N

Explain_____

_____

Describe motor development (handedness, coordination, energy output, etc.)

_____

_____

Describe child's social and emotional development: (shy, aggressive, cries easily, etc.)

_____

_____

If applicable, please describe any sensory preferences, such as seeking behaviors (e.g., hugs/affection, movements, mouthing)**and/or avoidance behaviors**(e.g., turning off lights, hitting, vocal noises, etc.)

_____

_____

_____

Any Additional Comments?_____

_____

_____

_____

_____

Parent/guardian signature **Date**