TDS Speech Pathology Associates, Inc.
232 North Main Street, Lower Level
East Longmeadow, MA 01028
Phone: (413) 525-6650 Fax: (413) 525-6620

Child Client
Family Information/Background History

Date: _____
Therapist: _____
Site: _____

FAMILY INFORMATION

Name of child: _____ Date of birth: _____

Age: _____ School attending: _____ Grade: _____

Person completing form: _____ Relationship to child: _____

Address: _____

Telephone: _____

Name of family members living at home: _____

_____

Language(s) spoken at home: _____

Who is referring your child for a Speech/Language evaluation: _____

_____

Why are they being referred: _____

_____

MEDICAL HISTORY

Name of pediatrician/specialist currently seeing child: _____

Were there any problems during pregnancy or during birth? YES / NO

Please explain: _____

_____

Was your child born before the due date? YES / NO

If so, when: _____

Has your child been hospitalized at any time? YES / NO

Please explain: _____

_____

Has your child had his/her vision or hearing checked? YES / NO

Results: _____

_____

Are you concerned about your child's vision? YES / NO

Please explain: _____

_____

Are there any diagnosed mental, physical or emotional difficulties? YES / NO

Please explain: _____

_____

Does your child have allergies? YES / NO

If so, what type: _____

Medications: _____

Is there a family history of speech and language difficulties? YES / NO

Please explain: _____

_____

Is there a family history of language learning difficulties? YES / NO

Please explain: _____

_____

DEVELOPEMENTAL MILESTONES

At approximately what age did your child:

*Babble: _____ *Use simple words: _____

*Begin combining words: _____ *Walk: _____

*Toilet train: _____

ORAL MOTOR

Is your child a good eater? YES / NO

Does he/she eat a variety of foods? YES / NO

Does your child have any food aversions or dislike certain textures of food? YES / NO

If so, please describe: _____

_____

Does your child "overstuff" his/her mouth when eating? YES / NO

Does your child choke or gag when eating? YES / NO

Does your child drool excessively? YES / NO

Does your child have any dental issues (i.e., rotting teeth, overbite, braces, etc)? YES / NO

Please explain: _____

_____

Will your child be fitted for braces anytime in the near future? YES / NO

HEARING STATUS

Does your child:

*Answer when you talk to him/her? YES / NO
*Talk in a very loud voice? YES / NO
*Turn up the volume on the radio or TV? YES / NO
*Have an oversensitivity to loud noises? YES / NO
*Hear you if his/her back is turned? YES / NO
*Hear you if you talk to him/her from another room? YES / NO
*Have a history of ear infections? YES / NO *How many: _____
*When was the most recent: _____
*Does he/she have tubes? YES / NO left ear _____ right ear _____ both ears _____
* Has he/she had tubes in the past? YES / NO When: _____
* Do you have any concerns about your child's hearing? YES / NO
Please explain: _____

_____

Has your child had a hearing test? YES / NO

If yes, where and when: _____

Results: _____

UNDERSTANDING LANGUAGE

When you talk to your child, how much does he/she understand? Check all that apply:

( ) A few words
( ) Many words or phrases
( ) Simple directions
( ) Multiple directions
( ) Almost everything I say

Additional comments/examples: _____

_____

EXPRESSIVE LANGUAGE

How does your child let you know what he/she wants? Check all that apply:

( ) Cries
( ) Points to what he/she wants
( ) Uses gestures with or without sounds or words
( ) Makes a few sounds
( ) Makes many different sounds
( ) Uses a few words
( ) Says many words but only one word at a time
( ) Says two or three word sentences
( ) Uses long sentences
( ) Gets frustrated when speaking
( ) Uses echo-like speech (repeats exactly what you say)

Additional comments/examples: _____

_____

ARTICULATION

Do you have to "interpret" your child's speech for others? YES / NO
Can the family understand your child's speech? YES / NO
Can others outside the family understand your child's speech? YES / NO
Does your child get frustrated when he/she is not understood? YES / NO
Are there any specific sounds that your child has difficulty saying? YES / NO

Please list: _____

FLUENCY / VOICE

Does your child frequently repeat words or parts of words when speaking? YES / NO
Does your child get frustrated when getting "stuck" on a word? YES / NO
Does your child show signs of tension when stuck on a word (i.e., straining muscles in the neck, eye blinks, etc.) YES / NO
Does your child demonstrate irregular breathing when speaking? YES / NO
Is there a family history of dysfluencies? YES / NO

Please explain: _____

_____

Does your child have a "different" sounding voice? YES / NO
If so, how would you describe it:_____

_____

Does your child's voice ever "crack" when speaking? YES / NO
Does your child's voice sound "full"? YES / NO
Does your child have a history of vocal nodules? YES / NO Polyps? YES / NO
Does your child clear his/her throat frequently? YES / NO

PRAGMATIC (Social) LANGUAGE

Does your child:
*Make eye contact while speaking with others? YES / NO
*Initiate topics of conversation? YES / NO
*Talk about a variety of things? YES / NO
*Maintain conversations with peers? YES / NO *With adults? YES / NO
*Enjoy interacting with peers? YES / NO

What does your child like to talk about: _____

_____

PREVIOUS THERAPY/TREATMENT

My child HAS / HAS NOT been enrolled in therapy/treatment before.

Comments about previous therapy/treatment: (OT/PT/ or Speech) _____

_____

_____

_____

Is your child still receiving these therapy services? YES / NO

If so, where: _____

Please comment on the main focus of therapy: _____

_____

_____

I am concerned about: (rank the most important to the least important)

1. _____
2. _____
3. _____