

Texas Tech University Health Sciences Center
Speech-Language & Hearing Clinic
Child Speech-Language and Hearing History
Birth to 4

The information you provide in this questionnaire will help us assess your child. Please fill out this form, answering questions about your child as completely as possible. If there are any items you do not fully understand, please discuss them with the supervisor during the assessment appointment.

IDENTIFYING INFORMATION

Today's Date:	Birthdate:	Male/Female	Age:
Child's Name:		Child's Social Security #:	
Address:			
City:		State:	Zip:
Person Completing Form:			
Daytime Phone:		Evening Phone:	
Name of Insurance and Primary Care Physician:			
Policy #:		Is physician referral required?	

HOME AND FAMILY INFORMATION

Father's Name:	Occupation:
Social Security Number:	Work Phone:
Last grade completed in school:	Age:
Mother's Name:	Occupation:
Social Security Number:	Work Phone:
Last grade completed in school:	Age:
Child lives with:	
Languages spoken in home:	

ASSESSMENT CONCERNS

What are the concerns regarding your child's communication, hearing, and/or swallowing skills?
--

OTHER CHILDREN IN THE FAMILY

Name	Age	Sex	Grade Level	List any speech, hearing, learning, or medical problems

PREGNANCY HISTORY

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Prenatal Problems			Blood Incompatibility		
Prenatal Alcohol Exposure			Pre-or Eclampsia		
Prenatal Drug Exposure			Gestational Diabetes		
Herpes			Cytomegalovirus		
Toxoplasmosis			Rubella		

BIRTH HISTORY	Yes	No		Yes	No
Premature Birth			Ventilation Used		
Birth Trauma			Neonatal Infection		
Intensive Care After Birth			Meningitis		
Blood Transfusion					
Apgar Scores (if known):			Birthweight:		

DEVELOPMENTAL INFORMATION

Give the age at which the child did the following:

Sat Alone:	Was Toilet Trained:
Crawled:	Said First Words:
Walked Alone:	Combined Two Words (Ex: "me go")
Fed Self:	

MEDICAL HISTORY	Yes	No	Date Occurred/Diagnosis	Description
Head Injuries				
Earaches				
Vision Problems				
Frequent Colds				
Meningitis				
Tonsillitis				
High Fevers				
Allergies				
Convulsions/Seizures				
Headaches				
Accidents (falls, burns)				
Serious Infections				
Other Brain/Spinal Problems				
Surgeries				
ADD/ADHD				
Autism				
Please list any other illnesses or injuries that were not mentioned above.				

List Current Medications	Dosage	Reason for taking

HEARING AND EAR HISTORY	Description
Do you think your child's hearing is poor?	
Does your child complain of noises in the ears or head?	
Does your child have dizziness or imbalance?	
Age at first ear infection (diagnosed by nurse or doctor)	
Number of ear infections age 0-2 years	
Number of ear infections age 2-4 years	
Last ear infection (date or age)	
Ear surgeries (ages, ear operated on, and type of surgery)	
Has child used hearing aids?	

TESTS DONE	Where	Date	Age	Results
Hearing Test				
Speech/Language				
Vision Exam				
Neurological (EEG)				
Psychological				
IQ Test Scores (if known): Verbal: Performance: Full Scale:				
Brain CT Scan or MRI				

FAMILY HISTORY **Description (relationship to child and type of problem)**

Ex: Speech Problems: Uncle who stutters; Learning Problems: Mother who has ADHD

Neurologic Diseases	
Speech Problems	
Learning Problems	
Hereditary Illness	
Ear/Hearing Problems	

SOCIAL/EMOTIONAL/SENSORY **Yes** **No** **Sometimes** **Yes** **No** **Sometimes**

Note: Depending upon your child's age, some of these items will not apply. Only mark the items which pertain to your child.

Trouble understanding television programs				Appears confused in noisy places			
Sensitivity to loud sounds				Often says "huh" or "what"			
Trouble telling where sounds are coming from				Mixes up sounds			
Problems following directions				Restless			
Easily distracted				Problem sitting still			
Forgetful				Rowdiness			
Preference for playing with younger children				Preference for playing with older children or adults			
Disruptive				Headaches			
Preference for solitary activities				Short attention span			
Easily frustrated				Temper tantrums			
Tires easily				Easily flustered or confused			
Often tense or anxious				Hyperactive			
Uncooperative				Disobedient			
Clumsy				Shy			
Impulsive				Irritable			
Lacks self-confidence				Destructive			
Easily upset by new situations				Excessive talking			
Withdraws from touch				Seeks attention			
Bothered by labels in shirts				Is bothered by bright lights			
Overreacts to small bumps, scrapes, etc.				Craves spinning or swinging			
Pinches or bites himself or others				Dislikes going barefooted or having arms or legs bare			
Exhibits poor posture - tires easily				Appears unaware of the feelings of others			
Bored or fussy when eating (poor appetite)				Likes only highly textured or cruchy foods			
Complains of things "smelling bad"				Plays too roughly			
Experiences car sickness				Walks on toes			

Please further explain items checked above:

Please list some of the child's interests, hobbies, playmates, and favorite play activities.

SPEECH/LANGUAGE PROBLEMS**(If not, skip this section.)**

	<u>Yes</u>	<u>No</u>	<u>Sometimes</u>	<u>Description</u>
Delay in early speech development				
Small vocabulary compared to peers				
Poor grammar usage				
Problems speaking clearly				
Stuttering				
Problems understanding others				
Speech therapy now or in the past				
How does the child respond when you talk to him/her (Ex: smiles, coos, babbles, talks, does not respond)?				
How does the child let you know what he/she wants? (circle all that apply) Gestures Single Words Short phrases Sentences Crying Pointing Other _____				
What efforts have been made to help the child talk better?				
Can you remember a time when your child's speech and language development seemed to stop? If so, please explain.				

EATING & SWALLOWING PROBLEMS**(If not, skip this section.)**

	<u>Yes</u>	<u>No</u>	<u>How Long</u>	<u>Describe</u>
Is/was your child breast-fed?				
Is/was your child fed through a feeding tube?				
Does your child feed him/herself?				
Does your child choke during meals?				
Does your child have trouble breathing while eating?				
Does your child gag during meals?				
Does your child cry during meals?				

EATING & SWALLOWING CONTINUED

	<u>Yes</u>	<u>No</u>	<u>How Long</u>	<u>Describe</u>
Does your child have reflux during/after meals?				
Does your child vomit during/after meals?				
Does your child have a gurgly voice quality before, during, or after feeding/eating?				
Does your child have any posture changes during feeding/eating (stiffening, hyperextending)?				
Does your child dislike being touched around the face or mouth?				
What do you think caused or is causing your child's feeding/eating problems?				
Have you seen a doctor regarding your child's feeding/eating problems? Yes/ No. If so, what was the diagnosis?				
What seems to help (or not help) your child during mealtime?				

School Services

Does the child currently attend preschool or daycare? Yes No (circle one)
Please list the name and phone number of the child's care provider.

RELATED SERVICES

<u>Does the child receive services from</u>	<u>Yes</u>	<u>No</u>	<u>Enrollment number</u>
Medicaid?			
CIDC?			
Texas Department of Health PACT?			
Texas Rehab Commission (TRC)?			

ADDITIONAL INFORMATION

Please list any other information you feel would be helpful in assessing your child's speech, language and/or swallowing abilities.
Please describe the problem for which you are being referred.
Please tell us what you hope to gain from the assessment.
What questions would you like answered during the assessment?

Name of person completing this form _____
 Relationship to the child _____
 Signature _____

Thank you for your time and effort filling out this questionnaire. Please mail or fax this document to:

Speech-Language & Hearing Clinic
Texas Tech University Health Sciences Center
3601 4th Street- Stop 6073
Lubbock, Texas 79430-6073
Fax: (806) 743-5670