

Texas Tech University Health Sciences Center
Speech-Language & Hearing Clinic
Child/Adolescent Speech-Language and Hearing History
5 to 17 years old

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:	(circle) Male/Female	Age:
Client's Name:		Client'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

BIRTH HISTORY

	Yes	No		Yes	No
Prenatal Problems			Ventilation Used		
Prenatal Alcohol Exposure			Neonatal Infection		
Prenatal Drug Exposure			Meningitis		
Premature Birth			Herpes		
Blood Incompatibility			Cytomegalovirus		
Blood Transfusion			Toxoplasmosis		
Intensive Care Unit After Birth			Rubella		
Apgar Scores (if known):			Birthweight:		

DEVELOPMENTAL INFORMATION

Give the age at which he/she did the following:

Sat Alone:	Dressed Self:
Crawled:	Rode Tricycle:
Walked Alone:	Tied Shoes:
Fed Self:	Said First Word:
Was Toilet Trained:	Combined Two Words (Ex: "me go"):

MEDICAL HISTORY	Yes	No	Date Occurred/Diagnosis	Description
Head Injuries				
Convulsions/Seizures				
Headaches				
Accidents (falls, burns)				
Serious Infections				
Other Brain/Spinal Problems				
Surgeries				
ADD/ADHD				
Auditory Processing Disorder				
Autism				
Oppositional Defiance Disorder				
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 his/her hearing is poor?	Yes	No	
Does he/she complain of noises in the ears or head?	Yes	No	
Does he/she have dizziness or imbalance?	Yes	No	
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:			
Number of ear infections age 4-6 years:			
Last ear infection (date or age):			
Ear surgeries (ages, ear operated on, and type of surgery)	Yes	No	
Has he/she used hearing aids?	Yes	No	

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 Illnesses	
Ear/Hearing Problems	

SOCIAL/EMOTIONAL/SENSORY	Yes	No	Sometimes		Yes	No	Sometimes
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				Needs quiet to study			
Easily distracted				Restless			
Daydreams				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			
Lacks motivation				Temper tantrums			
Easily frustrated				Easily flustered or confused			
Tires easily				Hyperactive			
Often tense or anxious				Disobedient			
Uncooperative				Shy			
Clumsy				Irritable			
Impulsive				Destructive			
Lacks self-confidence				Excessive talking			
Easily upset by new situations				Seeks attention			
Has problems with time concepts (Ex: before, after, tomorrow)				Does not complete assignments			
Fakes illnesses				Dislikes school			
Low achievement in school				Problems with the law			
Involved with drugs				Involved with alcohol			
Withdraws from touch				Is bothered by bright lights			
Bothered by labels in shirts				Craves spinning or swinging			
Overreacts to small bumps, scrapes, etc.				Dislikes going barefooted or having arms or legs bare			
Pinches or bites himself or others				Appears unaware of the feelings of others			
Exhibits poor posture - tires easily				Holds pencil too hard/soft or writes too hard/soft on paper			
Bored or fussy when eating (poor appetite)				Likes only highly textured or crunchy foods			
Complains of things "smelling bad"				Messy eater - frequent spills			
Experiences car sickness				Has/had difficulty learning to ride a bike			
Plays too roughly				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

Yes

No

Sometimes

Describe

(If not, skip this section.)

Delay in early speech development				
Small vocabulary compared to peers				
Poor grammar usage				
Problems speaking clearly				
Stuttering				
Problems understanding others				
Problems retelling events at school or stories				
Problems following classroom rules (Ex: doesn't raise hand to speak)				
Problems understanding written language				
Able to write complete sentences				
Problems following directions				
Problems giving directions				
Problems understanding jokes				
Problems in language arts class				
Asks for help when doesn't understand	Asks for help when doesn't understand			
Speech therapy now or in the past				

EATING & SWALLOWING PROBLEMS

(If not, skip this section.)

Yes

No

How Long

Describe

Does he/she have swallowing problems?				
Was he/she breast-fed?				
Was he/she fed through a feeding tube?				
Does he/she feed him/herself?				
Does he/she choke during meals?				
Does he/she have trouble breathing while eating?				
Does he/she gag during meals?				
Does he/she cry during meals?				
Does he/she have reflux during/after meals?				
Does he/she vomit during/after meals?				
Does he/she have a gurgly voice quality during/before, or after feeding?				
Does he/she have any posture changes during feeding (stiffening, hyperextending)?				
Does he/she dislike being touched around the face or mouth?				
What do you think caused or is causing his/her feeding problems?				
Have you seen a doctor regarding his/her feeding problems? _____ If so, what was the diagnosis?				
What seems to help (or not help) him/her during mealtime?				

SCHOOL/EDUCATIONAL INFORMATION

School currently attending:	Grade in school:
Best subject(s):	
Poorest subject(s):	
What type of classroom does he/she attend? (circle one) mainstream alternative special education mainstream with content mastery mainstream & special education other: _____	
Type(s) of therapy or assistance:	
Does he/she have an IEP?	
What are some of his/her goals addressed in the IEP?	
Has he/she ever repeated a grade?	
Does he/she like school?	
Are you satisfied with school support? If no, please explain:	
Has his/her teacher ever expressed concern for his/her progress? If yes, please explain:	

RELATED SERVICES

<u>Does he/she receive services from?</u>	<u>Yes</u>	<u>No</u>	<u>Enrollment numbers</u>
Medicaid			
CIDC			
Texas Department of Health PACT			
Texas Rehab Commission			

Please list any other information you feel would be helpful in assessing his/her speech, language skills and/or swallowing skills.

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:

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