BACKGROUND HISTORY FORM

Child's Name_______________________________ **Birth Date**________ **Today's Date**___________

Age_________ Parents/Guardians Full Names____

Siblings and Ages ____

Primary Language Spoken In the Home________________ Other Languages _____________________

Referred By_______________________________________

Person Completing this Form __________________________ Relationship to Child _________________

Birth Information (Check All Those That Apply)

Complications/Health Problems During Pregnancy:

Diabetes_____ Measles_____ Toxemia_____ Premature Labor____ Strep_______ Respiratory________

Other____

Complications During Labor/Delivery

Cesarean Section______ Emergency? Y N Forceps______ Vacuum______ Other________________

Medications Given During Delivery____

Describe Child's Condition At/Or Immediately After Birth:

Premature_____ (If Yes) Gestational Age____ Apgars_____ NICU_______ (If Yes)How Long?________

Ventilator____ (If Yes) How Long?________ Jaundice_____ Heart Problems_____ Poor Suck__________

Small For Gestational Age_______________ Large For Gestational Age_______________

Known Diagnosis (e.g. Down Syndrome) ____

Other Medical Complications ____

Child's Medical History:

Measles______ Mumps______ Pneumonia_______ Chicken Pox______ Bronchitis _______ BPD _____

Reflux______ Allergies_______ Head Injuries _______ Tonsillitis _______ Other ___________________

Ear Infections_______ Frequency______________ Last Ear Infection________________________

Treatment Method __________________________

List Any Hospitalizations:

Dates (from ___ to ____) Reason Hospital

Dates (from ___ to ____)	Reason	Hospital
________________________	______________________	__________________
________________________	______________________	__________________
________________________	______________________	__________________

List Any Surgery Performed:

Ear Tubes______ Still In Place?_____ Central Line______ Spinal Infusions_______ G-Tube_________

Heart Repair________ Trach_______ Shunt_______ Tonsillectomy______ Appendectomy___________

Other____

Tests Performed:

MRI_____ CT Scan_____ Genetic Testing____ X-Rays_____ Other_____________________________

Please List Current Medications: ____

____

Has The Child Had Any Seizures? Y or N Please Describe And Indicate Frequency________________

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<u>Child's Developmental History:</u>

Developmental Milestones:

Please List The Approximate Age The Child Accomplished The Following:

Lift Head While On Tummy_______ Rolled Over_____ Sat Without Support______ Crawled______

Stood Alone______ Walked Alone______ Dress/Undress Self______ Button/Zip Clothes_________

Started Solid Foods______ Held Cup_ Used Fork______ Drank From: Sippy Cup____ Open Cup_______

Dry During Day_____ Dry At Night_______ Gain Bowel Control_______ Hand Preference: L R

Does Your Child Have Any Bowel Or Bladder Difficulties? Please Describe_______________________

____

Speech:

Please List The Approximate Age The Child Accomplished The Following:

Babble (dada, baba, etc.)__________ Said First Words__________ Combined Words________________

Does Your Child Respond When His/Her Name Is Called? Y N Follow Simple Directions? Y N

Approximately How Many Words Does Your Child Have? ______________

How Does Your Child Tell You What He/She Wants? ____

Check Any Areas of Concern Regarding Speech and Language:

Length of Statements Your Child Uses ________ Ability to Produce Sounds Correctly _________

Ability to Find the Right Word (i.e., I want that, uh, thing that, uh, goes around) __________

Fluency of Speech (e.g., I-I-I will go to-to-to-to school now.) __________

Quality of Voice (e.g., nasal, hoarse, pitch) __________ Ability to Sustain Attention ___________

Ability to Stay on Topic ___________ Ability to Initiate a Topic __________

Ability to Establish Peer Relationships ____________ Ability to Follow Directions ____________

When Did You First Notice Difficulties with Your Child's Speech and Language? __________________

Does Your Child Become Frustrated Due to These Difficulties? _________________________________

Family History of Speech and Language Difficulties? Please Describe ___________________________

Feeding:

Does Child Have Any Feeding Difficulty With The Following:

Poor Suck______ Difficulty Swallowing______ Difficulty Chewing_______ Gag/Choke Often________

Finger Feeding_______ Spoon Use________ Required A Feeding Tube_____ Reflux/Vomiting_______

List Any Other Feeding Concerns____

Is Your Child a Picky Eater? Y N Does Your Child Dislike Particular Textures of Food? Y N

What is Your Child's Favorite Food? _________________ Least Favorite Food? __________________

Hearing/Vision:

Has Your Child Ever Had A Vision Test? Y N If Yes, Date Last Performed___________________

Results____

Does Your Child Wear Glasses? Y N

Has Your Child Ever Had A Hearing Test? Y N If Yes, Date Last Performed___________________

Results____

Does Your Child Wear A Hearing Aide? Y N If Yes, Please Indicate L R

Sensory History:

Does Your Child's Hands, Feet, And/Or Tummy Seem Overly Sensitive To Touch? Y N

Does Your Child Seem Distractible Or Overactive? Y N If Yes, Please Describe________________

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Does Your Child Tolerate Toothbrushing? Y N

Educational History:

What School Does Your Child Attend? _____________________________ Current Grade Level _______

How Often Does He/She Attend School? __________ days per week __________ hours per day

What Are Your Child's Strengths in School? ____

What Areas at School Are Most Difficult for Your Child? _______________________________________

Additional Information:

Please List Any Behavioral Issues____

Please Explain Why You Want This Evaluation Done________________________________

____

Has Your Child Had Any Previous Evaluations/Therapy? Y N

If Yes, Please Provide Dates, Facility Where Performed, Type Of Therapy And Reason(s)__________

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Please List Any Pertinent Family Medical History_________________________________

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Is There Anything Else That You Would Like Us To Know About Your Child?______________

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Thank you for taking the time to complete this form. The information you provided is valuable in assessing your child's skills.