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www.bostonspeech.com

### Identifying and Family Information:

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: ☐ M ☐ F

Father's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_ E-mail: \_\_\_\_\_

\_\_\_\_\_

Mother's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_ E-mail: \_\_\_\_\_

\_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

### Child lives with (check one):

☐ Birth Parents

☐ Foster Parents

☐ One Parent

☐ Adoptive Parents

☐ Parent and Step-Parent

☐ Other \_\_\_\_\_

### Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems
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### Child's race/ethnic group:

☐ Caucasian, Non-Hispanic

☐ Hispanic

☐ African-American

☐ Native American

☐ Asian or Pacific Islander

☐ Other \_\_\_\_\_

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? \_\_\_\_\_

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Who speaks the language? \_\_\_\_\_

Which language does the child prefer to speak at home? \_\_\_\_\_

## Speech-Language-Hearing

Do you feel your child has a speech problem?

☐ Yes

☐ No

If yes, please describe. \_\_\_\_\_

Do you feel your child has a hearing problem?

☐ Yes

☐ No

If yes, please describe. \_\_\_\_\_

Has he/she ever had a speech evaluation/screening?

☐ Yes

☐ No

If yes, where and when? \_\_\_\_\_

What were you told? \_\_\_\_\_

Has he/she ever had a hearing evaluation/screening?

☐ Yes

☐ No

If yes, where and when? \_\_\_\_\_

What were you told? \_\_\_\_\_

Has your child ever had speech therapy?

☐ Yes

☐ No

If yes, where and when? \_\_\_\_\_

What was he/she working on? \_\_\_\_\_

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)?

☐ Yes

☐ No

If yes, please describe. \_\_\_\_\_

Is your child aware of, or frustrated by, any speech/language difficulties? \_\_\_\_\_

What do you see as your child's most difficult problem in the home? \_\_\_\_\_

What do you see as your child's most difficult problem in school? \_\_\_\_\_

## Birth History

Was there anything unusual about the pregnancy or birth?

☐ Yes

☐ No

If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

How old was the mother when the child was born? \_\_\_\_\_

Was the mother sick during the pregnancy?

☐ Yes

☐ No

If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

How many months was the pregnancy? \_\_\_\_\_

Did the child go home with his/her mother from the hospital?

☐ Yes

☐ No

If child stayed at the hospital, please describe why and how long. \_\_\_\_\_

\_\_\_\_\_

## Medical History

Has your child had any of the following?

☐ adenoidectomy

☐ encephalitis

☐ seizures

☐ allergies

☐ flu

☐ sinusitis

☐ breathing difficulties

☐ head injury

☐ sleeping difficulties

☐ chicken pox

☐ high fevers

☐ thumb/finger sucking habit

☐ colds

☐ measles

☐ tonsillectomy

☐ ear infections

☐ meningitis

☐ tonsillitis

How often? \_\_\_\_\_

☐ mumps

☐ vision problems

☐ ear tubes

☐ scarlet fever

Other serious injury/surgery: \_\_\_\_\_

Is your child currently (or recently) under a physician's care?

☐ Yes

☐ No

If yes, why? \_\_\_\_\_

\_\_\_\_\_

Please list any medications your child takes regularly: \_\_\_\_\_

\_\_\_\_\_

## Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

\_\_\_\_\_ sat alone  
\_\_\_\_\_ babbled  
\_\_\_\_\_ put two words together  
\_\_\_\_\_ walked

\_\_\_\_\_ grasped crayon/pencil  
\_\_\_\_\_ said first words  
\_\_\_\_\_ spoke in short sentences  
\_\_\_\_\_ toilet trained

### Does your child...

- ☐ choke on food or liquids?
- ☐ currently put toys/objects in his/her mouth?
- ☐ brush his/her teeth and/or allow brushing?

## Current Speech-Language-Hearing

### Does your child...

- ☐ repeat sounds, words or phrases over and over?
- ☐ understand what you are saying?
- ☐ retrieve/point to common objects upon request (ball, cup, shoe)?
- ☐ follow simple directions ("Shut the door" or "Get your shoes")?
- ☐ respond correctly to yes/no questions?
- ☐ respond correctly to who/what/where/when/why questions?

### Your child currently communicates using...

- ☐ body language.
- ☐ sounds (vowels, grunting).
- ☐ words (shoe, doggy, up).
- ☐ 2 to 4 word sentences.
- ☐ sentences longer than four words.
- ☐ other \_\_\_\_\_.

### Behavioral Characteristics:

- |  |  |
|--|--|
| <input type="checkbox"/> cooperative                               | <input type="checkbox"/> restless                          |
| <input type="checkbox"/> attentive                                 | <input type="checkbox"/> poor eye contact                  |
| <input type="checkbox"/> willing to try new activities             | <input type="checkbox"/> easily distracted/short attention |
| <input type="checkbox"/> plays alone for reasonable length of time | <input type="checkbox"/> destructive/aggressive            |
| <input type="checkbox"/> separation difficulties                   | <input type="checkbox"/> withdrawn                         |
| <input type="checkbox"/> easily frustrated/impulsive               | <input type="checkbox"/> inappropriate behavior            |
| <input type="checkbox"/> stubborn                                  | <input type="checkbox"/> self-abusive behavior             |

## School History

**If your child is in school, please answer the following:**

Name of school and grade in school: \_\_\_\_\_

Teacher's name: \_\_\_\_\_

Has your child repeated a grade? \_\_\_\_\_

What are your child's strengths and/or best subjects? \_\_\_\_\_

Is your child having difficulty with any subjects? \_\_\_\_\_

Is your child receiving help in any subjects? \_\_\_\_\_

## Additional Comments

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