HISTORY

NAME: _____ DATE: _____

ADDRESS: _____ DATE OF BIRTH: _____

City: _____ State: _____ Zip Code: _____

HOME PHONE: _____ REFERRAL SOURCE: _____

OCCUPATION OF RESPONSIBLE PARTY: _____

EMPLOYER: _____

ADDRESS OF EMPLOYER: _____

PARENT #1 NAME: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL ADDRESS: _____

PARENT #2 NAME: _____ WORK PHONE _____

CELL PHONE: _____ EMAIL ADDRESS: _____

BROTHERS AND SISTERS:

NAMES	AGE	SEX	LEARNING DIFFERENCES/DEFICITS

CLIENT'S PHYSICIAN: _____

DESCRIPTION OF PROBLEM: (Use back if needed) _____

_____

_____

SIGNIFICANT FAMILY HISTORY:

Deafness: _____

Epilepsy or genetic disorders: _____

Mental illness: _____

Similar complaint in immediate family: _____

EDUCATIONAL OR EMPLOYMENT HISTORY:

School or place of employment: _____

Grade: _____ Teacher: _____ Average: _____

Previous testing or treatment by other professionals: _____

Academic tutoring, remedial work, or therapy: (Describe) _____

_____

PRE-NATAL AND BIRTH HISTORY:

Illnesses of Mother: _____

RH Incompatibility: _____

Accidents: _____

Previous miscarriages: _____

Length of Pregnancy: _____ Birth Weight: _____

Complications: _____

CLIENT'S HEALTH RECORD:

Diseases affecting the ear: (middle ear infections, tubes in ears, tonsillitis, etc.)

Surgery: _____

Allergies: _____

Seizures: _____

Accidents: _____

Is client presently being medicated for any condition? If so, what? _____

PHYSICAL ABNORMALITIES:

OTHER:

MOTOR DEVELOPMENT: Please indicate ages at which your child did the following:

Sitting up: _____ Crawling: _____ Walking: _____

Hand preference: _____ Toilet training: _____

LARGE MUSCLE COORDINATION:

Running: _____ Jumping: _____ Throwing: _____

Catching: _____ Balancing: _____ Etc. _____

SMALL MUSCLE COORDINATION:

Writing: _____ Coloring: _____

Buttoning: _____ Etc. _____

LANGUAGE AND SPEECH (Please indicate ages)

Random cooing, babbling of sounds: _____ First Words: _____

Two-word combinations: _____ Three or more word combinations: _____

Was your child a noisy or quiet baby? _____

In your opinion, did speech and language skills develop normally? _____

_____

Voice quality (hoarseness, loss of voice, etc.): _____

Was there any difficulty understanding child's speech? _____

BEHAVORIAL DEVELOPMENT : (hyperactivity, poor sleeping habits, tantrums, inappropriate behavior?)

_____

_____

_____

_____

SOCIAL AND EMOTIONAL DEVELOPMENT: (cooperative play, relationships with adults and children, reactions to school, new situations?)

_____

_____

_____

_____