SPEECH AND HEARING CLINIC
THE PENNSYLVANIA STATE UNIVERSITY
110 FORD BUILDING; UNIVERSITY PARK, PA 16802
V / TDD# (814) 865-5414

Early Language Group
Child History Information

Please answer the questions below. You may wish to consult several sources (baby book, medical records, etc.). **This information is for confidential use and will aid us in assessing whether the Early Language Group is a good fit for your child.**

After answering the questions, please return the form to the Penn State Speech and Hearing Clinic @ 110 Ford Building, University Park, PA 16802 or fax to 814-863-3759. When we receive all forms, we will contact you about a specific appointment date. Thank you.

Date:______________________________

Child's Name:	Date of Birth:
Address:	Present Age:
Parent/guardian contact information:	Sex:
Phone number:	Nickname:
Email address:	Grade:
Cell phone number:	School:

Family Information / People with Whom the Child Lives

Father's Name and Age:	Occupation:
Mother's Name and Age:	Occupation:
Siblings Names and Ages:	
Others in the household:	

Does the child speak English? YES, ALWAYS YES, SOMETIMES NO

Does the child speak any languages other than English? YES NO

If YES, what language(s) does he/she speak? ____

If any of the people listed above speak a language other than English, please list which people and what language(s) they speak.

List significant activities, interests, events, hobbies, favorite toys, etc. for your child.

Who typically takes care of your child?

Parent How often, and for how long?

Daycare or babysitter How often, and for how long?

Preschool How often, and for how long?

How did you find out about the Early Language Group?

What would you like your child to gain from the Early Language Group?

Medical and Developmental History

1. **Prenatal**

Mother's age when child was born___________ Father's age when child was born__________

Length of pregnancy in weeks__________ Birth weight___________

How long was the infant's stay in the hospital following birth?_____________________________

Yes	No	*If any questions are answered "yes", please provide additional information below.*
		Did the mother experience bleeding during pregnancy?
		Did the mother have measles during pregnancy?
		Did the mother have high blood pressure during pregnancy?
		Did the mother experience leakage of membranes during pregnancy?
		Were there complications (e.g., anemia, dehydration, diabetes, kidney infection, severe nausea, toxemia, accidents, etc.) during this pregnancy?
		Were prescription/non-prescription drugs (including alcohol) taken during pregnancy?

2. **Birth**

Yes	No	*Other than the 1st question, if any questions are answered "yes", please provide additional information below.*
		Did the mother have a vaginal delivery with this child?
		Did the mother have a breech delivery?
		Did the mother have a Caesarean Section delivery?
		Were there birth injuries?
		Were there breathing difficulties (e.g., blue baby, required oxygen, stopped breathing, apnea, other____)
		Were special instruments used during delivery?
		Was the baby jaundiced at birth?
		Was there Rh incompatibility?
		Were there any problems or complications following birth or during the first two weeks of your infant's life (feeding, seizures, sleeping, swallowing, hospitalizations, etc.)?

3. **Development (give age when each milestone first occurred)**

Age	**Motor Skill**	**Age**	**Motor Skill**
	Held head up		Fed self with spoon
	Sat up unsupported		Bladder Trained
	Reached for object		Bowel trained
	Crawled		Dressed Self
	Stood alone		Undressed Self
	Walked alone		

Do you have any motor or self-help concerns for this child? If so, please describe.

4. **Child's Medical History**

Please check all conditions that your child has had or presently has:

___allergies ___asthma ___chicken pox ___convulsions ___dental problems

___epilepsy/seizures ___apraxia ___headaches ___head injury ___high fevers ___measles

___meningitis ___mumps ___muscle disorder ___nerve disorder ___traumatic brain injury

___ear infection

Are there any foods your child cannot eat due to allergies, intolerance, or other dietary restrictions?

Please list any medications the child is taking presently:______________________________________

Does your child have any health concerns or diagnosed disabilities that have not been covered above? If so, please describe.

Child's Communication Skills

Speech Production: Check and provide examples / descriptions where applicable

	Sounds are not produced at all (e.g., "look" is pronounced as "ook")
	Sounds are substituted for with other sounds (e.g., "cat" is pronounced as "tat")
	Sounds are not produced clearly (e.g., "s" sounds slushy)

Expressive Language: Check and provide examples descriptions where applicable

Yes	No	*If any questions are answered "yes", please provide additional information.*
		Did the child begin to babble or talk and then stop?
		Child is not talking, but may be using gestures.
		Child is only saying a few words.
		Child is talking, but only puts a few words together at a time.
		Child is talking, but there are errors in grammar.

Please indicate all means of communication currently used:

___Speech ___Vocalizations

___Bodily Gestures ___Facial Gestures ___Shakes head for yes/no

___Takes person to item ___Spoken yes/no ___Manual Signs ___Pointing

___Augmentative Communication Device

List any adaptive equipment currently used and describe your child's ability to communicate with the device :____

Receptive Language: Check and provide examples descriptions where applicable

How well does the child understand what is said to him/her?

	Understands gestures
	Does not understand spoken words *[continued on next page]*

	Understands single words
	Understands simple sentences
	Understands / follows 1step directions
	Understands / follows 2 step directions
	Understands / follows 3 step directions
	Understands conversation

Do you have any concerns about your child's hearing? If so, please describe.

Has your child been evaluated by another professional?

Type of Evaluation Completed:____

Date of most recent test:___________ Where tested:_______________________________________

By Whom?________________________________ Test Results and Recommendations:

*A copy of the evaluation report would be helpful.