

Olmos Speech, Language and Learning Clinic

5800 Broadway, Suite 106 / San Antonio, Texas 78209/ 828-5583 - Fax (210) 828-4129

History Form

Information

Name: _____

School: _____

Address: _____

Grade: _____

_____ Zip: _____

Person completing this form: _____

Parents: _____

Relationship to client: _____

Address (if not the same): _____

Date: _____

_____ Zip: _____

Referred by whom (school, doctor, agency, individual, other) _____

Phone: _____ Cell: _____

Why is the child being referred: _____

email: _____

Date of birth: _____

Age: _____ Sex: _____

Family Information

Mother's Information:

Circle one: Biological - Adoptive - Step

Name: _____

Age: _____ Health: _____

Education: _____

If deceased, date and cause: _____

Marital Status: _____

Occupation: _____

Employer: _____

Business Address: _____

Business Phone: _____

Father's Information:

Circle one: Biological - Adoptive - Step

Name: _____

Age: _____ Health: _____

Education: _____

If deceased, date and cause: _____

Marital Status: _____

Occupation: _____

Employer: _____

Business Address: _____

Business Phone: _____

Other children in the family:

Name _____ Age _____

_____ _____

_____ _____

_____ _____

Living in the home

Yes _____ No _____

Yes _____ No _____

Yes _____ No _____

Do any of the children have special problems (speech, hearing, language, academic, emotional, behavioral, medical or other?) Describe: _____

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History Form (page two)

Are any of the children adopted? _____ Yes _____ No

Names: _____ Age at the time of adoption: _____

Other persons living in the home (and relationship to client): _____

Is there any language spoken in the home other than English? If yes, what is the dominant language spoken in the home? _____

Are there any family problems which you feel might be contributing to the present difficulties of the child (such as illness, death, frequent school changes, absence of either parent, etc?) _____

Is there a history of speech, language or learning difficulties in the family? _____

Please describe: _____

Birth & Neonatal History

Mother's age at time of pregnancy? _____ Number of pregnancies? _____

Which pregnancy was this child? _____ Any miscarriages? _____

Where there any unusual conditions associated with this pregnancy (x-rays, German Measles, toxemia, high blood sugar, RH negative, bleeding, illnesses, seizures, surgery, drugs or medication)? _____

Please describe: _____

Type of delivery: Normal _____ Induced _____ Breech _____ Caesarean _____

Were anesthetics used? _____ Forceps? _____

Were there complications during delivery? _____

Was this birth premature? _____ Period of gestation: _____ Birth weight: _____

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History Form (page three)

Was the baby a twin? _____ Was there a need for special treatment at birth? _____

Was there any problems during the first several months after birth? _____

Motor Development

Give the ages for the following:

Feed self: _____ Sitting: _____ Standing: _____ Walking: _____ Bladder Control: _____ Bowel Control: _____

Did he/she appear to be delayed in developing motor skills such as climbing, running, skipping, riding a tricycle, riding a bicycle, roller skating, etc.? _____

Did he/she fall frequently? _____ Does he/she appear to be clumsy? _____

Which hand does he/she prefer to use? _____

Does he/she use this hand consistently? _____

At the present time, are there any difficulties with eating, sleeping or bladder control? _____

Speech and Language Development (Birth to Preschool)

At what age did he/she use single words? _____ 3 or 4 word sentences? _____

Was early speech easily understood by the family? _____

Did he/she have difficulty understanding what was said to him/her? _____

Did he/she pay attention to what was said to him/her? _____

Was he/she able to follow oral instructions? _____

Did he/she recall and recount happenings? _____

Did he/she enjoy being read to? _____

Did he/she enjoy watching television? _____

Did he/she have difficulty correctly sequencing words in a sentence? _____

Did he/she have difficulty expressing his/her thoughts, ideas or feelings? _____

Did he/she ever become frustrated if others were unable to understand him/her? _____

Did he/she have difficulty using words correctly, such as verb tenses, plurals, pronoun usage, etc.? _____

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History Form (page four)

Did he/she ever prefer to communicate by using gestures instead of speech? _____

In comparison to other children his/her age, do you feel vocabulary development was:

Limited _____ Normal _____ Advanced _____

Medical

Name of physician: _____

Were there any illnesses or injuries that were long term, traumatic or that required surgery? _____ Yes _____ No

If yes, Please describe: _____

Is he/she on any type of medication? _____ Yes _____ No

If yes, what type and for what reason: _____

Has your child had any of the following diseases or disorders?

Frequent sore throats: _____

Frequent colds: _____

Allergies: _____

Asthma: _____

Frequent Headaches: _____

Convulsive Seizures: _____

Other (describe): _____

Is there a history of otitis media (middle ear infection)? _____ Yes _____ No

If yes, how frequent and age of occurrence: _____

Type of treatment for otitis media: _____

Describe general physical condition: _____

Has his/her hearing ever been tested? _____ Yes _____ No. If yes, when? _____

Where: _____

Results: _____

Has his/her vision ever been tested? _____ Yes _____ No. If yes, when? _____

Where: _____

Results: _____

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History Form (page five)

Education

Schools attended:

Place: _____ Grade: _____

Has he/she ever repeated a grade? ____ Yes ____ No. If yes, which? _____

How does the teacher describe your child's behavior in school? _____

Does he/she like school? _____

Are any school subjects difficult for him/her? ____ Which ones: _____

What kind of grades does he/she receive? _____

Have grades changed significantly in his/her school history? ____ Yes ____ No

If yes, please explain: _____

Has he/she ever received services in school (speech, resource, reading specialist, counselor)? _____

Please describe (grade and specific service): _____

Has your child received educational support outside of school? ____ Yes ____ No

If yes, when: _____ Where: _____

Have there been previous educational/psychological evaluations of your child? ____ Yes ____ No

If yes, when: _____ Where: _____

Social and Emotional History

Does he/she get along well with brothers and sisters? ____ Yes ____ No

Does he/she prefer to play alone? ____ Yes ____ No

Does he/she prefer to play with younger children? ____ Yes ____ No

Does he/she prefer to play with older children? ____ Yes ____ No

Do older children seek him/her out to play? ____ Yes ____ No

Does he/she make friends easily? ____ Yes ____ No

Is he/her behavior consistent with his/her age? ____ Yes ____ No

Explain: _____
