HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
Audiology: 206.323.5770
Speech: 206.388.1300
www.hsdc.org

Pediatric History Form

Child's Name______________________ Today's Date __________

Date of Birth__________________ Age __________ Gender __________

Person Filling out Form ______________ Relationship to Child __________

I. Describe any major concern(s) about your child: ______________________

____

____

____

II. What specific questions would you like to have answered:

____

____

____

III. Prenatal and Birth History:

1. During this pregnancy, did the mother experience any unusual illness, accident or condition, such as German measles, high blood pressure, bleeding, Rh incompatibility? If so, please describe: ______________________

   ____

2. During the pregnancy did the mother (*please check)*

   ☐ Drink alcohol? ☐ Smoke?

   ☐ Take medication? ☐ Take recreational drugs?

   Please describe:______________________

3. Were there any complications with delivery? ☐ Yes ☐ No

   Please describe: ______________________

   Birth weight:__________How many weeks gestation at time of delivery: __________

4. Condition of baby at birth (bruised, jaundiced, difficulty breathing, etc.): __________

   ____

   Color good? ☐ Yes ☐ No Breathed easily? ☐ Yes ☐ No

   Incubated? ☐ Yes ☐ No Spent time in NICU? ☐ Yes ☐ No

   If yes, please describe length and reason of stay in Neonatal Intensive Care Unit (NICU): ______________________

   ____

IV. Feeding History

1. Any feeding difficulties immediately after birth? ☐ Yes ☐ No

   If yes, what kind?______________________

   My child was: ☐ Breast fed ☐ Bottle fed ☐ Both

2. Current feeding abilities (types of food/liquid and how often): __________

   ____

   Has your child ever gained/lost weight that was considered atypical? __________

   Does your child need special spoons or cups? ☐ Yes ☐ No

   My child has difficulty with (check all that apply): ☐ Chewing ☐ Swallowing

   My child dislikes certain foods: ☐ Yes ☐ No Examples: __________

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V. Development

1. At what age did the child:

Wean from breast: ________ Wean from bottle: ________ Stop using pacifier: ________

Drink from sippy cup: ________ Drink from open cup: ________ Feed self: ________

Sit independently: ________ First crawl: ________ Walk Independently: ________

Stop thumb sucking: ________ Gain bowel control: ________

Gain bladder control ________

2. Describe your child's:

Overall development: ________

Coordination and balance: ________

Self-help skills (dressing, washing, etc.): ________

Fine motor skills (using scissors, coloring, writing, etc.): ________

Handedness: ☐ Right ☐ Left ☐ Undetermined ☐ Ambidextrous

VI. Medical History

1. General

Does your child have frequent colds? ☐ Yes ☐ No

History of fevers? ☐ Yes ☐ No

History of seasonal allergies? ☐ Yes ☐ No

History of ear infections? ☐ Yes ☐ No

Most recent ear infection: ________ How was it treated? ________

Other medical conditions or diagnoses: ________

____

Is the child in good health at this time? ☐ Yes ☐ No, Explain: ________

When was your child's most recent physical examination? ________

Physician: ________ Clinic/Hospital: ________

Current medications: ________

Please list all allergies: ________

Please list all illnesses, accidents, and operations:

DATE	AGE	TYPE	DURATION	SEVERITY	HOSPITAL

2. Hearing

Does the child have a suspected or known hearing loss? ☐ Yes ☐ No

Does anyone in the child's biological family have a hearing loss? ☐ Yes ☐ No

Please list: ________

Has your child had a hearing test before? ☐ Yes ☐ No

If yes, where? ________ When? ________

What were the results? ________

Does your child wear hearing aids? ☐ Yes ☐ No If yes, for how long? ________

Has your child seen a physician for an ear examination? ☐ Yes ☐ No

When? ________ Results: ________

Physician: ________ Clinic/Hospital: ________

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VII. Social/Education History

1. Social History

My child prefers to play (check all that apply):

☐ Alone ☐ With Others ☐ With Adults
☐ With Older Children ☐ With Younger children

Does your child have tantrums frequently? ☐ Yes ☐ No If so, how often?______________

What are some of your child's favorite activities?______________________________

What types of activities/interactions does your child least enjoy?______________________

How would you describe your child's personality?______________________________

2. Educational History

My child is now enrolled in (check all that apply):

☐ School ☐ Preschool ☐ Daycare ☐ None

Name of Daycare:______________________Hours and days per week:__________

Name of School/Preschool: ______________District: ______________________

Teacher's Name: ______________________Grade: ______________________

Speech Pathologist: ____

Strengths in school: ____

Areas of difficulty: ____

Special therapies or services in school:________________________________

VIII. Speech/Language

1. History

Do you have any family history of speech/language delays or disorders? ☐ Yes ☐ No

If yes, please specify: ____

At what age did your child do the following?

Begin to babble:______________Say first word: ______________

Put words together:______________Use short sentences: ______________

Examples: ____

____

2. Current Speech/Language Abilities

Can you usually understand what your child says? ☐ Yes ☐ No

Percentage of understanding: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Can others understand what your child says? ☐ Yes ☐ No

Percentage of understanding: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Is your child aware of her/his speech difference? ☐ Yes ☐ No

Does your child:

Readily imitate sounds, words, and/or sentences you say?

Respond to her/his name? ☐ Yes ☐ No

Point to pictures that you name? ☐ Yes ☐ No

Follow directions? ☐ Yes ☐ No

Ask/answer questions? ☐ Yes ☐ No

Relate events to you? ☐ Yes ☐ No

Understand more than s/he says? ☐ Yes ☐ No

Appear frustrated if s/he is not understood? ☐ Yes ☐ No

If yes, how is this frustration expressed? ______________________

Use sign language or other gestures to communicate? ☐ Yes ☐ No ☐ Sometimes

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3. Stuttering
   Does your child stutter? ☐ Yes ☐ No ☐ Sometimes
   Types of stuttering (*check all that apply*):
   ☐ Whole word repetitions ☐ Syllable repetitions ☐ Sound repetitions
   ☐ Sound prolongations ☐ Total blocking
   How long has this been occurring? ______________________________

4. Voice
   Does your child frequently have a hoarse voice or lose her/his voice? ☐ Yes ☐ No

5. Other Therapy Services
   Please list all current and previous services, including evaluations, and therapy sessions. Example: Speech pathology, physical therapist. *Please provide name, address, and date*

Dates	Age	Service Type (Speech, OT, PT):	Provider:	Location:

6. **Please list any other speech/language concerns, or any information you feel is important for us to know**: ______________________________
   ____

IX. Special Health Considerations/Precautions

HSDC Staff will review charts and pay special attention to any disclosed healthcare needs (e.g., seizures, pacemaker, diabetes, etc.) Please describe any special precautions or procedures we may need to know in case of emergency:

____
____
____
____
____

X. Emergency Contact:

Name: ______________________________ Relationship: ______________

Email: ______________________________ Phone: ______________