

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: _____

V. Development

1. At what age did the child:

Wean from breast _____ Wean from bottle: _____ Stop using pacifier: _____
 Spoon feed: _____ Drink from open cup: _____ Feed self: _____
 Drink from straw: _____
 Sit independently: _____ First crawl: _____ Walk Independently: _____
 Gain bladder control: _____ Gain bowel 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: _____

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? Yes No

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

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:

