budding voices

Background/Medical History Form

Today' Date: _____

Child's Name: _____ Date of Birth: _____

Name of Person Completing the Form:_____

Relationship to the Child: ☐ parent ☐ legal guardian ☐ other_____

Diagnosis: (please include date given and by whom) _____

_____

_____

Pregnancy & Birth History

Child was born ☐ pre-mature ☐ full term ☐ past due at _____weeks gestation

Any complications during pregnancy? ☐ no ☐ yes If yes, please describe: _____

_____

_____

Any complications at birth? ☐ no ☐ yes If yes, please describe: _____

_____

_____

Delivery: ☐ Cesarean ☐ vaginal ☐ breech ☐ feet first ☐ forceps assisted ☐ vacuum assisted

Did the child require any medical assistance following birth? ☐ no ☐ yes If yes, please describe:____

_____

_____

Did the child go home from the hospital with the mother? ☐ yes ☐ no If no, please explain:

_____

_____

Mother's age at birth: _____ Was this the mother's first pregnancy? ☐ yes ☐ no _____

Family History

Other children in the home

Name	Age	Male or Female	Any speech/language/hearing problems?

Any language other than English spoken at home? □ no □ yes _____

List any family members with relevant speech/language/hearing/educational/medical problems

Name	Age	Relation to child	Diagnosis/problem

Developmental History

Indicate the approximate age the child achieved each of the following milestones

Sat unsupported		**Babbled**	
First word		**Combined words**	
Used sentences		**First solid food**	
Used spoon/fork		**Crawled**	
Weaned from bottle/breast		**Used sippy cup**	
Weaned from pacifier		**Used open cup**	
Walked		**Smiled**	
Ran		**Pointed**	
Used crayon		**Toilet trained**	
Slept through night		**Dressed self**	

Do you or did you have any concerns related to you child achieving developmental milestones on time? □ no □ yes If yes, please explain: _____

Does the child have a dominant hand? □ right □ left □ both □ unsure

Feeding History

As an infant, the child was □ breast fed □ bottle fed □ both - For how long? _____

Any concerns regarding latch as an infant? □ no □ yes If yes, please explain: _____

Any concerns regarding or repairs related to lip/tongue tie(s) as an infant? □ no □ yes If yes, please explain: _____

Did the child have any feeding problems in infancy? □ colic □ reflux □ gas □ other - Please describe: _____

Does the currently child have any difficulty eating or swallowing? □ no □ yes If yes, please describe: _____

Does the child choke or gag while eating or drinking? □ no □ yes If yes, please describe: _____

Does the child put non-food items, toys, or objects in his/her mouth? □ no □ yes If yes, please describe: _____

Does your child brush his/her teeth or allow brushing? □ yes □ no If no, please describe: _____

Do you have any concerns related to your child's teeth? □ no □ yes If yes, please describe: _____

What are your child's favorite foods? _____

Does your child refuse any foods? _____

Does the child have any sensitivities to □ taste □ texture □ temperature? If yes, please describe: ___

Does the child self-feed? □ no □ yes - The child can use □ spoon □ fork □ straw □ open cup

Medical History

How would you describe your child's current general health?_____

Has your child received all recommended vaccinations for his/her age? □ yes □ no If no, please explain: _____

Please check if your child has had any of the following and indicate the age:

□ seizures	□ high fever	□ measles	□ mumps
□ chicken pox	□ whooping cough	□ diphtheria	□ croup
□ pneumonia	□ tonsilitis	□ meningitis	□ encephalitis
□ rheumatic fever	□ tonsillectomy	□ tuberculosis	□ chronic colds
□ enlarged glands	□ thyroid disease	□ asthma	□ flu
□ ear infections	□ ear tubes	□ sinusitis	□ seasonal allergies
□ vision problems	□ hearing problems	□ heart problems	□ scarlet fever

Please indicate any other serious illness, medical diagnosis, or surgery you child has had: _____

_____

_____

_____

_____

Is you child currently under the care of a physician? □ no □ yes If yes, please explain: _____

_____

_____

_____

Please list any medications your child takes regularly:

Medication	Dose/Frequency	Reason

Please indicate any other information regarding your child's medical history not covered above: _____

_____

_____

_____

Speech-Language History

Does anyone in the family, including aunts/uncles/cousins, have speech-language difficulties? □ no

□ yes - If yes, explain: _____

_____

_____

Please describe how your child currently communicates with you (e.g., grunting, body language, pulling, crying, words, augmentative communication system): _____

_____

_____

_____

Please check all that apply to your child:

□ says words	□ asks for things	□ uses 2-4 word sentences
□ uses 5+ word sentences	□ understands adults	□ understands other kids
□ understood by parents	□ understood by other adults	□ understood by other kids
□ follows directions	□ makes sound errors	□ is frustrated when talking
□ imitate funny faces	□ can blow horns/bubbles	□ can make raspberries
□ engages in pretend play	□ plays alone	□ plays with other kids
□ repeats sounds over & over	□ repeats words over & over	□ repeats sentences over & over
□ answers yes/no questions	□ answers wh- questions	□ points to show interest
□ points to objects named	□ looks when you point	□ responds to his/her name

Has your child ever participated in a speech-language evaluation? □ no □ yes - If yes, explain:

_____

_____

_____

Please explain your concerns related to your child's speech-language skills: _____

_____

_____

_____

_____

Do you have any concern about your child's hearing? □ no □ yes - If yes, please explain: _____

_____

Has your child's hearing been tested? □ no □ yes - If yes, were the results normal? □ yes □ no - If no, please explain: _____

Has your child ever taken a pacifier? □ no □ yes - If yes, for how long? _____

Has your child ever sucked his/her thumb or fingers? □ no □ yes - If yes, how long? _____

Has you child ever received speech-language therapy? □ no □ yes - If yes, where and when?

_____

_____

Anything else you'd like to tell us about your child's speech-language development? _____

_____

_____

_____

School History

Does your child currently attend school? (pre-school/daycare included) □ no □ yes

School name: _____ Grade: _____

Does your child have an IFSP/IEP? □ no □ yes - If yes, please explain: _____

_____

_____

Does/did your child receive an evaluation or services through Infants & Toddlers? □ no □ yes - If yes, please explain: _____

_____

Is you child in a special education classroom? □ no □ yes - If yes, please describe: _____

_____

Does your child have a dedicated educational assistant? □ no □ yes

Has your child ever repeated a grade? □ no □ yes - If yes, please explain: _____

_____

How would you describe your child's general performance in school/learning abilities? _____

_____

_____

_____

What are your child's best/favorite subjects? _____

_____

What are your child's worst/least favorite subjects? _____

_____

Anything else you'd like to tell us about your child's school history or education? _____

_____

_____

_____

Behavior

Do you have any concerns about your child's behavior? □ no □ yes - If yes, please explain: _____

_____

_____

_____

Please check all that apply to your child:

□ laughs at the right time	□ laughs at the wrong time	□ laughs less than expected
□ cries at the right time	□ cries at the wrong time	□ cries less than expected
□ cries more than expected	□ clingy to parents	□ shy
□ seeks attention often	□ hurts self when upset	□ hurts others when upset
□ responds to sound	□ ignores adults	□ breathes through the mouth
□ difficulty moving mouth	□ difficulty moving lips	□ difficulty moving tongue
□ lip tie	□ tongue tie	□ uncoordinated
□ problems at meal times	□ sleep problems	□ toilet training problems
□ difficulty concentrating	□ stays with an activity	□ needs a lot of discipline
□ difficult to manage	□ easy to manage	□ overactive
□ underactive	□ easily excited	□ sensitive
□ emotional	□ happy	□ gets along with other kids
□ plays with age level toys	□ sad	□ difficulty calming down
□ too fearful of strangers	□ not fearful of strangers	

Does your child separate from parents easily (without crying/fussing)? □ yes □ no - If no, please explain: _____

_____

Does your child see a behavior specialist? □ no □ yes - If yes, please explain: _____

_____

_____

Please describe your child's personality: _____

_____

_____

_____

What are your child's favorite toys/games? _____

_____

_____

Does your child have any difficult behaviors (e.g., tantrums, hitting, biting, not listening) □ no □ yes

If yes, please explain: _____

_____

_____

_____

How do you discipline your child? _____

_____

_____

_____

_____

Self-Care & Daily Routine

Please describe your child's sleep habits, including naps and over night: _____

_____

_____

_____

Please describe your child's eating habits, including # of meals, # of snacks, and any problems: _____

_____

_____

Please describe your child's typical day: _____

_____

_____

How does your child handle changes to his/her routine? _____

Anything else you would like to share with us? _____