Print Form

How to Submit History

THE UNIVERSITY OF SOUTH CAROLINA
SPEECH AND HEARING RESEARCH CENTER
1601 ST. JULIAN PLACE
COLUMBIA, SC 29204
Phone: 803-777-2614 Fax: 803 253-4143

CHILD SPEECH-LANGUAGE HISTORY

Date_____ Referred by _____
Physician's name _____
Person completing this form _____
Relationship to child _____

Patient Name _____ Birthdate _____ Age _____

Race of child: _____ Ethnic background of child: _____

Parents or Legal Guardian (Names): _____

Address: _____ City/State: _____ Zip: _____

Phone (home) _____ (work) _____ (cell) _____

County of Residence _____

Father's Occupation _____ Highest Grade Completed _____

Mother's Occupation _____ Highest Grade Completed _____

List other languages spoken in the home _____

Has your child had a hearing evaluation? ☐ No ☐ Yes Name of audiologist: _____
Reported results _____

How does your child communicate? (by speaking, pointing, signing, etc.) _____

_____

Describe your child's communication difficulty

_____

_____

HEALTH HISTORY OF CHILD

Pre-natal History (check any of the following that the mother experienced during pregnancy with this child)

	YES	NO	Which month(s)?
Bleeding	☐	☐	_____
Swelling	☐	☐	_____
High Blood Pressure	☐	☐	_____
Low Blood Pressure	☐	☐	_____
Convulsions	☐	☐	_____
Toxemia	☐	☐	_____
Rh Negative Blood	☐	☐	_____

Pre-natal History-continued (check any of the following that the mother experienced during pregnancy with this child)

	YES	NO	Which month(s)
German measles-Rubella	☐	☐	_____
Diabetes	☐	☐	_____
Accidents	☐	☐	_____
X-Rays	☐	☐	_____
Heart Condition	☐	☐	_____
Virus Infection	☐	☐	_____
Thyroid Condition	☐	☐	_____

Please list any other conditions: _____

_____

Birth History and Post-natal period (2 weeks of infant's life) Check the appropriate box)

	YES	NO	List condition/treatment
Anoxia or other breathing difficulties	☐	☐	_____
Jaundice	☐	☐	_____
Convulsions	☐	☐	_____
Infection	☐	☐	_____
Extended hospitalization or re-hospitalization	☐	☐	_____
Oxygen	☐	☐	_____
Transfusion	☐	☐	_____
Tube feeding	☐	☐	_____
Dehydration	☐	☐	_____

What was the length of this pregnancy? _____ Type of delivery? _____

Birth weight? _____ Time in hospital following birth? _____

Medical History of Child (Check the appropriate box)	YES	NO	Age and Treatment
Frequent colds	☐	☐	_____
Ear Infections	☐	☐	_____
PE tube insertion (for ears)	☐	☐	_____
Pneumonia	☐	☐	_____
Chicken pox	☐	☐	_____
Flu	☐	☐	_____
Measles	☐	☐	_____
Scarlet fever	☐	☐	_____
Mumps	☐	☐	_____
Whooping cough	☐	☐	_____
Tonsillectomy	☐	☐	_____
Adenoidectomy	☐	☐	_____
Allergies	☐	☐	_____
Asthma	☐	☐	_____
Epilepsy	☐	☐	_____

Medical History of Child – continued	YES	NO	Age and Treatment
Head Injury	☐	☐	_____
Encephalitis	☐	☐	_____
Meningitis	☐	☐	_____
Seizures	☐	☐	_____
Lead exposure	☐	☐	_____
Vision problems	☐	☐	_____
Hearing problems	☐	☐	_____
Feeding problems	☐	☐	_____
Swallowing difficulties	☐	☐	_____
Surgeries	☐	☐	_____
Dental problems	☐	☐	_____
Diagnosis of hyperactivity	☐	☐	_____
Diagnosis of Attention Deficit Disorder	☐	☐	_____
Diagnosis of Autism	☐	☐	_____
Diagnosis of Pervasive Development Disability	☐	☐	_____

List any other illnesses here: _____
_____

Please list **name** and **dosage** of all medications your child is currently taking and for **what illness** the medicine is prescribed:

Name of Medicine	Dosage	Illness/condition
_____	_____	_____
_____	_____	_____

DEVELOPMENTAL HISTORY

At what age did your child:

_____ sit alone? _____crawl? _____walk alone?

_____ babble? _____ say first word? _____combine 2-words?

_____ feed self? _____toilet independently? _____ combine 3 or more words?

List several of your child's first words: _____

List several of your child's phrases: _____

FAMILY/SOCIAL HISTORY

List the names and ages of your other children:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Indicate any family history of the following speech, language, hearing or learning difficulties in the family.

	YES	NO	Relationship
Difficulty producing a few sounds	☐	☐	_____
Speech difficult to understand by others	☐	☐	_____
Stuttering	☐	☐	_____
Hearing loss	☐	☐	_____
Learning disability	☐	☐	_____
Reading	☐	☐	_____
Writing	☐	☐	_____
Spelling	☐	☐	_____
Difficulty understanding spoken language	☐	☐	_____
Genetic disorder	☐	☐	_____

Name of genetic disorder: _____

Describe your child's:

Play behavior _____
_____
_____

Interests _____
_____
_____

Interaction with playmates, family members, etc. _____
_____
_____

EDUCATIONAL/HABILITATIVE HISTORY

Has your child had a previous speech and language evaluation? _____ If yes, when and by whom?
_____

Has your child received speech therapy in the past?_____If yes, where and for how long?
_____

*Does your child currently receive **speech** therapy**, physical therapy**, and/or **occupational** therapy?*
Speech therapy: Yes☐ No☐ Physical therapy: Yes☐ No☐ Occupational therapy:
If yes:
Where is your child receiving therapy? _____
What is your child's diagnosis? _____
How long has your child been receiving therapy?_____

List your child's school, school district and grade:_____
Teacher's name (grade or home room) _____
Favorite subjects _____
Any attending difficulties? (please describe) _____
_____
Any academic difficulties? (please describe) _____
_____

Please add any information or comments that you think might be helpful to us.
_____
_____
_____