EASTSIDE AUDIOLOGY
HEARING EXPERTS. SOUND ADVICE.

Child History Form

Child's Name: _____ Date of Birth: ____

Name of Person Completing this form: __ Relationship: ____

1. Describe your major concern about your child: _____

   _____

   _____

2. What specific questions would you like to have answered? _

   ___

   ___

3. Prenatal and Birth History:

   a. During pregnancy, did the mother experience any unusual illness, accident or condition (such as German measles, high blood pressure, bleeding, and RH incompatibility?) If so, explain: __

      ___

      ___

      Was pregnancy full term: _ If not, explain: _____

      ___

   b. Did the mother smoke? YES NO ___

      Did the mother drink alcohol? YES NO ___

      Take recreational Drugs? YEA NO ___ YES NO If yes, explain:

      Take medications? YES NO If yes, explain: ___

   c. Was delivery without complications?

   d. Birth Weight: __ Condition of baby at birth: ___

   e. Did your child experience feeding difficulty? YES NO If so, explain: ____

      ___

4. Development

a. At what age did your child:

Sit Independently __ Walk Independently _ First Crawl __

b. Overall Development (rapid, slow, average etc.):

c. Coordination and Balance: (good, fair, clumsy, awkward etc.) ___

5. Medical History:

a. Does your child have frequent colds? __ History of high fevers? _____

If yes, explain: _

Ear Infections: _ When most recently treated: _

Describe treatment: ____

___

b. Other medical conditions or diagnoses? ____

c. Does your child have suspected hearing loss: _____

d. Has your child had a hearing test before: YES NO If so, where? _

e. Has your child seen a doctor for an ear exam? YES NO When: __

f. Does anyone in your family have hearing loss? YES NO Please explain: _

_____

g. Is your child in good health at this time? ____

_____

h. Has your child been seen by the following? If so, please give name, address and date:

_____ Medical Specialist (Neurologist, ENT, Etc) ____

_____

_____ Social Worker _____

_____ Speech Pathologist __

_____ Physical or Occupational Therapist ___

_____ Audiologist __

_____ Other _____

6. Social History:

b. Does your child mostly prefer to play with others or mostly prefer to play alone? _____

c. When interacting with others, does your child prefer to play with adults, peers, older children or younger children? _

d. Does your child have frequent tantrums? ___ If so, how often? ____

e. What are your child's favorite activities? ____

f. How would you describe your child's personality? ___

7. Speech and Language History:

   a. At what age did your child begin to: Babble , Say first words ___,

      Put words together ____, Use complete sentences __

   b. Can you usually understand what your child says? _____ Can others? _____

   c. Does your child appear to understand more than s/he says? ___

   d. Does your child appear frustrated if s/he is not understood? ____

   e. Does your child imitate sounds, words and/or sentences you say? _____

   f. Is there ever a time when speech development appeared to stop? _____

      If so, explain: __

7. Is there any other information about your child you feel it is important for us to know? _

   _____

   _____