



# 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 \_\_\_\_\_

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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_