MARY K. CHAPMAN CENTER FOR COMMUNICATIVE DISORDERS
UNIVERSITY OF TULSA

OFFICE USE ONLY
DATE RECEIVED
DATE ATTEMPTED TO CONTACT
DATE SCHEDULED

HISTORY QUESTIONNAIRE - CHILDREN **CONFIDENTIAL**

NAME OF PERSON FOR WHOM APPOINTMENT IS REQUESTED AGE SEX DATE OF BIRTH

WHAT IS YOUR CHILD'S RACE/ETHNICITY? (OPTIONAL)

STREET ADDRESS CITY, STATE, ZIPCODE

PHONE NUMBERS E-MAIL

(HOME) **(CELL)** **(WORK)**

PREFERRED METHOD OF CONTACT (PLEASE CHECK)

HOME PHONE☐ **CELL PHONE** ☐ **WORK PHONE**☐ **E-MAIL**☐

NAME OF PERSON COMPLETING THIS FORM RELATIONSHIP TO CLIENT

METHOD OF PAYMENT (PLEASE CHECK)

PRIVATE PAY☐ MEDICAID ☐ MEDICAID # TU EMPLOYEE/ALUMNI DISCOUNT☐ WOULD LIKE TO APPLY FOR SCHOLARSHIP☐

NAME OF PERSON RESPONSIBLE FOR PAYMENT PHONE NUMBER

ADDRESS (STREET, NUMBER, CITY, STATE, ZIP CODE)

HOW WERE YOU REFERRED TO THE CLINIC?

DESCRIBE THE CHILD'S SPEECH AND LANGUAGE. WHY ARE YOU CONCERNED?

IF YOUR CHILD DOES NOT TALK HOW DOES HE/SHE COMMUNICATE?

THERAPY HISTORY:

Is your child currently receiving speech-language therapy or received it in the past from :	School Name of School: Dates:	Private Name of Facility: Dates:	Sooner Start Dates:	Other Name of Facility: Dates:
Is your child receiving other therapy services:	Physical Therapy Name of Facility: Dates:	Occupational Therapy Name of Facility: Dates:	Psychological Therapy Name of Facility: Dates:	Other Name of Facility: Dates:

FAMILY HISTORY:

MOTHER'S NAME AGE OCCUPATION BUSINESS PHONE

ADDRESS IF DIFFERENT FROM CHILD'S

FATHER'S NAME AGE OCCUPATION BUSINESS PHONE

ADDRESS IF DIFFERENT FROM CHILD'S

IF CHILD DOES NOT LIVE WITH BOTH PARENTS, WHO HAS LEGAL CUSTODY OF CHILD?

NAMES OF BROTHERS AND SISTERS	AGE	SEX	LIVING IN HOME WITH CHILD?	SPEECH PROBLEM?

RELATIVES OR OTHERS LIVING IN HOME **RELATIONSHIP**

WHAT LANGUAGES ARE SPOKEN IN THE HOME? **WHAT IS THE PRIMARY LANGUAGE IN THE HOME?**

IS THERE ANY FAMILY HISTORY OF SPEECH AND LANGUAGE DISORDERS?

BIRTH HISTORY

BORN AT - HOSPITAL, HOME, OTHER CITY STATE

HEALTH DURING PREGNANCY: Good ☐ Fair☐ Poor☐

BIRTH WEIGHT FULL TERM ☐ PREMATURE ☐ MULTIPLE BIRTH ☐ MEDICATIONS TAKEN: During Pregnancy At Birth

NUMBER OF WEEKS _____

DELIVERY ☐ NORMAL ☐ BREECH ☐Emergency C-SECTION ☐ C-Section

DID YOUR BABY NEED ANY SPECIAL CARE AT BIRTH OR IN THE DAYS IMMEDIATELY FOLLOWING BIRTH? No ☐ Yes☐

DID YOUR BABY RECEIVE CARE IN THE NEONATAL INTENSIVE CARE UNIT (NICU)? No ☐ Yes☐ If so, length of stay_____

PLEASE DESCRIBE SPECIAL SERVICES RECEIVED, MEDICATIONS RECEIVED AND DIAGNOSIS:

DEVELOPMENTAL HISTORY

GIVE THE APPROXIMATE AGE WHEN YOUR CHILD DID THE FOLLOWING:

MOTOR SKILLS

SAT ALONE _____
CRAWLED_____
STOOD ALONE_____
WALKED ALONE_____
WAS ABLE TO CLIMB STAIRS_____
WAS ABLE TO RUN 10 FEET_____

SPEECH-LANGUAGE SKILLS

BABBLED/COOED_____
SAID FIRST WORDS_____
HAD FIFTY WORDS_____
COMBINED TWO WORDS_____
USED SENTENCES OF THREE WORDS OR MORE_____

SELF-HELP SKILLS

WHEN DID THEY STOP BOTTLE FEEDING_____
FINGER FEED SELF_____
DRANK FROM A CUP_____
SELF-FED FROM SPOON_____
TOILET TRAINED_____
DRESSED SELF (PANTS AND SHIRT)_____

CHECK YES OR NO FOR THE FOLLOWING:

SOCIAL SKILLS

HAS EYE CONTACT WITH OTHERS	☐ YES	☐ NO
POINTS TO ITEMS OF INTEREST	☐ YES	☐ NO
RESPONDS WELL TO PEOPLE	☐ YES	☐ NO
PLAYS WITH OTHER CHILDREN	☐ YES	☐ NO
WARMS UP TO A SITUATION AFTER AN INITIAL PERIOD OF TIME	☐ YES	☐ NO
IS EXTREMELY ACTIVE OR RESTLESS	☐ YES	☐ NO
IS PHYSICALLY AGGRESSIVE	☐ YES	☐ NO
IS IMPULSIVE	☐ YES	☐ NO
DISPLAYS REPETITIVE BEHAVIORS	☐ YES	☐ NO

MEDICAL HISTORY

NAME AND ADDRESS OF FAMILY PHYSICIAN OR PEDIATRICIAN

IS CHILD RECEIVING ANY MEDICAL TREATMENT NOW? IF SO, DESCRIBE

DOES YOUR CHILD HAVE ANY SPECIFIC MEDICAL DIAGNOSES?

DOES YOUR CHILD HAVE ANY FOOD ALLERGIES OR SPECIAL DIETARY PRECAUTIONS?

LIST ILLNESSES, INJURIES, CHILDHOOD DISEASES AND OPERATIONS. GIVE DATES AND LENGTH OF HOSPITAL STAY

ILLNESS, INJURY, OPERATION	DATE	HOSPITAL/LENGTH OF STAY

DID YOUR CHILD PASS A NEWBORN HEARING SCREENING?

☐NO ☐ YES

ARE YOU CONCERNED ABOUT CHILD'S HEARING?

☐ NO ☐ YES - Explain:

IS THERE A HISTORY OF HEARING LOSS, EAR INFECTIONS, ETC.

☐ NO ☐ YES - Explain

HAS YOUR CHILD BEEN DIAGNOSED WITH HEARING LOSS? PLEASE LIST TYPE OF LOSS AND SEVERITY OF LOSS.

☐ NO ☐ YES

DOES CHILD WEAR HEARING AID(S) WHERE AND WHEN FITTED

☐ NO ☐ YES ☐ LEFT EAR ☐ RIGHT EAR ☐ BILATERAL

DOES YOUR CHILD HAVE A COCHLEAR IMPLANT? DATE AND PLACE OF IMPLANTATION SURGERY.

☐ NO ☐ YES ☐ LEFT EAR ☐ RIGHT EAR ☐ BILATERAL

HAS CHILD BEEN EXAMINED BY AN EAR, NOSE AND THROAT DOCTOR? DATE OF LAST EXAMINATION

☐ NO ☐ YES

NAME AND ADDRESS OF EAR, NOSE AND THROAT DOCTOR

HAS YOUR CHILD BEEN EXAMINED BY AN AUDIOLOGIST? DATE OF LAST EXAMINATION

☐ NO ☐ YES

NAME AND ADDRESS OF AUDIOLOGIST

SCHOOL HISTORY

NAME OF SCHOOL PRESENTLY ATTENDING ADDRESS

NAME OF TEACHER GRADE

SCHOOLS PREVIOUSLY ATTENDED	**CITY,**	**STATE**

LIST SCHOOL SUBJECTS WHICH CHILD DOES WELL

LIST ANY SPECIAL CLASSES ATTENDED OR SERVICES RECEIVED

LIST ANY SUBJECTS WHICH ARE ESPECIALLY DIFFICULT

ARE THERE ANY SERIOUS BEHAVIORAL PROBLEMS IN SCHOOL?

PLEASE GIVE ANY ADDITIONAL INFORMATION YOU FEEL WILL HELP US BETTER UNDERSTAND AND PLAN FOR YOUR CHILD

ON OCCASION, WE USE REWARDS DURING EVALUATIONS AND THERAPY. PLEASE CHECK THE FOLLOWING REWARDS THAT ARE ACCEPTABLE TO USE WITH YOUR CHILD:

☐ CANDY (MINI-M&M'S OR SMARTIES) ☐ STICKERS/STAMPS ☐ SMALL PRIZES OR TOYS OTHER_____

RECORDS POLICY

All client records are confidential. No information will be released without the consent of the client or the person legally responsible for the client. If you want results from this evaluation to be sent to other individuals or agencies, please complete a separate release form. All information is kept confidential as outlined in our privacy practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

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