Confidential History

Parent/Guardian: _____ Today's Date: _____

Child's Name:_____ DOB:_____ Age:_____ Grade:_____

School: _____ Form Completed by: _____

Mother's Name: _____ Best Phone Number: _____

Address: _____

Email Address: _____

Father's Name: _____ Best Phone Number: _____

Address: _____

Email Address: _____

Referred By: _____

May we send a thank you letter to your referral source? Yes: _____ No: _____

_____ has my permission to send a thank you letter to my referral source indicating that my child has been seen for an evaluation. No other information will be released without written consent.

Parent/Guardian: _____ Date: _____

Family Members

Member Name	Sex	Age	Adopted	Education/Occupation	Handedness
	M / F		Y / N		R / L
	M / F		Y / N		R / L
	M / F		Y / N		R / L
	M / F		Y / N		R / L
	M / F		Y / N		R / L
	M / F		Y / N		R / L

Marital Status of Parents: Married: ___ Separated: ___ Divorced: ___ Other: ___

What are your concerns for your child? Academic: ___ Personal: ___ Social: ___ Communication: ___

Family Adaptation

At home, how would you describe your child's general adjustment? Poor: ___ Fair: ___ Good: ___ Excellent: ___

How does your child get along with each member of the family?

Father:

_____

Mother:

_____

Siblings:

_____

Have there been any traumatic family events in the course of the child's development?

_____

_____

_____

Have there been any major moves? (City to city, country to country)

_____

Pregnancy/Delivery (If child was adopted, turn to page 3)

What kind of experience was the pregnancy for both mother and father?

Father: _____

Mother: _____

More specifically:		More specifically:	
Was it planned?	Y / N	Full term?	Y / N
Where there complications?	Y / N	Length of labor?	Y / N
Shock?	Y / N	Forceps used?	Y / N
Loss of a loved one		High forceps required?	Y / N
during pregnancy?	Y / N	Delivery position? (i.e. breech)	Y / N
Accident?	Y / N	Caesarean birth? (reason)	Y / N
Heath problems?	Y / N	Birth weight?	_____
Confinement to bed?	Y / N	APGAR rating?	_____
Tiredness, fatigue?	Y / N	Cried immediately?	Y / N
Other?	Y / N	Required special treatment?	Y / N
Was mother exposed to noise?	Y / N	(oxygen, jaundice, etc.)	
Did mother smoke?	Y / N	Did baby have immediate	
Did mother consume alcohol?	Y / N	physical contact with mom?	Y / N
Did mother take any medication?	Y / N	Was there a positive bonding	
Did mother talk much?	Y / N	experience between mom	
Was mother physically active?	Y / N	and baby at birth?	Y / N
Did mother sing?	Y / N	Was baby breastfed?	Y / N

Did mother play musical instruments?	Y / N	Any separations from mom and baby during first days of life.	Y / N
Previous complicated pregnancies?	Y / N	Did mom experience any post-partum depression?	Y / N
Language spoken by mother? _____	_____		

Describe your experience during labor and delivery:

_____
_____
_____

Adoption

Describe the circumstances surrounding the adoption:

_____
_____
_____

More Specifically:

Age when adopted: _____

Prior foster home: _____

Physical appearance: _____

Response to new home: _____

Is your child aware of adoption: _____

Infancy

Going back to the first two years of your child's life, what type of baby was he/she? (feeding, sleeping, activity)

_____
_____
_____

More specifically:		Comments
Breastfed?	Y / N	
Extended separations during		
first two years? (over 3 days)	Y / N	
Specific health problems during		
this period?	Y / N	
Toilet trained? Age?		
Thumb sucking? Until what age?	Y / N	
Feeding or sleeping problems?	Y / N	

Childhood Illnesses/Conditions

Please list any allergies:

_____

_____

Has your child had any of the following childhood illnesses? (check all that apply)

		Frequency			Frequency
___	Headaches		___	Snoring	
___	Head injury		___	Hearing Loss	
___	Heart problems		___	Birth Defect	
___	Muscle disorder		___	Bowel Problems	
___	Nerve disorder		___	Gastro esophageal Reflux	
___	Tonsillitis		___	Colic	
___	Upper Respiratory		___	Dehydration	
	Vision problems			Failure to Thrive	
___	Chicken Pox		___	Digestion Problems	
___	Asthma		___	Sleep Problems	
___	High fever		___	Over/Under Reaction	
___	Meningitis		___	to noise	Over/ Under
___	Ear infections/tubes		___	to clothing	Over/ Under

____		_____	____	
____	Adenoid problems	_____	____	to smell Over/ Under
____	Frequent colds	_____	____	to taste Over/ Under
____	Strep throat	_____	____	to movement Over/ Under

Has your child been hospitalized? If yes, please list reasons:

_____

_____

Has your child ever had a serious accident/injury? If yes, please list accidents:

_____

_____

Check the items below which apply to your child and give details.

_____	Asthma	_____
_____	Bronchitis	_____
_____	Craniofacial problems	_____
_____	Skin problems	_____
_____	Gastro Intestinal problems	_____
_____	Convulsions	_____
_____	Dental problems	_____
_____	Epilepsy/Seizures	_____
_____	Nightmares	_____
_____	Fitful sleep	_____
_____	Bedwetting	_____
_____	Nail biting	_____

Feeding

What professionals has your child seen to get help related to feeding problems?

Gastroenterologist	_____	Phone	_____
Otolaryngologist	_____	Phone	_____
Pulmonologist	_____	Phone	_____
Neurologist	_____	Phone	_____
Chiropractor	_____	Phone	_____
Occupational Therapist	_____	Phone	_____

Speech Therapist		Phone	
Nutritionist		Phone	
Naturopath		Phone	
Other		Phone	

What test has your child had to help get information related to feeding problems?

1. Upper GI; Barium Swallow? Y / N
2. Bronchoscopy? Y / N
3. Video fluoroscopic Swallow Study? Y / N
4. Other? Y / N

Are there any other medical illnesses or conditions which have not been diagnosed?

_____

_____

Is your child in good health at the present time? _____

Is your child currently taking any prescribed medication? If yes, please list name and dose.

_____

_____

When was your child's most recent medical check-up? Date and Doctor's name.

_____

What feeding methods do you use to feed your child? Please give information as to when various feeding methods were started or stopped.

Breast Feeding	Y / N	Age Stopped	
Bottle Feeding	Y / N	Age Stopped	
Spoon (fed by adult)	Y / N	Age Stopped	
Cup (with assist)	Y / N	Age Stopped	
Finger Feeding	Y / N	Age Stopped	
NG Tube Feeding	Y / N	Age Stopped	
Tube Feeding	Y / N	Age Stopped	

Comments:

_____

_____

Mealtime information for oral feeding (answer if your child eats regularly by mouth)

How many meals are offered each day? _____

How many snacks are offered each day? _____

Are meals and snacks offered on a schedule (the same time each day)? _____

How does your child let you know they are hungry?

_____

_____

Is your child always fed in the same room? Yes ___ No ___ Which Room _____

Where does your child sit to eat? High Chair ___ Chair at the table ___ Other _____

Who is the main person feeding your child? _____

Who else is with your child when they are eating? _____

How long do meals last? _____

How does your child let you know they are done eating? _____

List the foods that your child **WILL** eat and drink, putting a star beside your child's favorites.

Meats	Vegetables	Fruits	Dairy	Grains	Liquids

List the foods/drinks that your child **REFUSES**.

Meats	Vegetables	Fruits	Dairy	Grains	Liquids

List any foods/drinks that your child is **ALLERGIC** to.

Meats	Vegetables	Fruits	Dairy	Grains	Liquids

Mealtime information for tube feeding (answer if your child gets any food through a tube).

What type of tube does your child have? G-tube ___ PEG ___ NG tube ___ Other _____

Is feeding by bolus or drip? _____

Estimate the percentage of your child's nutrition that is given by tube? 100% __ 75% __ 50% __ 25% __

Where is your child located when tube feedings are given? _____

Who usually give the tube feedings? _____

Check the items below which describe problems that your child has with feeding. Add comments about relevant items.

Feeding Behavior		Comments
Refuses bottle	Y / N	
Refuses breast	Y / N	
Refuses solid food	Y / N	
Takes only one texture	Y / N	
Eats limited variety of food	Y / N	
Coughs/Chokes during feeding	Y / N	
Vomits during feeding	Y / N	
Vomits between feeding	Y / N	
Gags frequently	Y / N	
Cries during feeding	Y / N	
Has tantrums during feeding	Y / N	
Runs away during feeding	Y / N	
Throws/Spits food	Y / N	

Needs to be distracted to eat	Y / N	
Won't sit still to eat	Y / N	
Doesn't seem hungry	Y / N	
Amount eaten is unpredictable	Y / N	
Seems to have pain with eating	Y / N	
Seems to be afraid of eating	Y / N	
Wakes frequently at night to feed	Y / N	
Gaining weight poorly	Y / N	

Sensory-Motor Development

How would you describe your child's motor development? Normal ___ Delayed ___ Advanced ___

At what age did your child: Crawl ___ Walk ___ Develop hand preference: Right ___ Left ___ Mixed ___

Is your child unusually sensitive to touch or are some clothes "scratchy"? If yes, please describe.

_____

_____

General coordination?	poor		fair		good		excellent	
General balance?	poor		fair		good		excellent	

Does your child participate in sports? Type. _____

Visual Development

Has your child experienced any problems with his/her eyesight or vision?

_____

_____

Are there any current problems of which you are aware?

_____

_____

When was the last time his/her eyesight was tested?

_____

_____

Auditory Development

Did your child pass the newborn hearing test? Yes ___ No ___

Has your child experienced any problems with his/her hearing? (operations, infections, tubes)

_____

_____

Ear infection?	seldom	_____	sometimes	_____	often	_____
	mild	_____	moderate	_____	severe	_____

Are there any current hearing problems of which you are aware?

_____

_____

Speech and Language Development

How would you describe your child's speech and language development?

Normal ___ Delayed ___ Advanced ___

Did your child begin speaking in single words, then two, then a sentence? OR

Did your child not talk for a long while, then all of a sudden speak in complete sentences?

_____

_____

First words (list examples and age)

_____

_____

Describe any speech related problems:

_____

_____

_____

Has your child had any of the following assessments?

		Place	Date
Audio logical	Y / N	_____	_____
Speech	Y / N	_____	_____
Sensory Integration	Y / N	_____	_____
Psychological	Y / N	_____	_____

Has your child been previously diagnosed as having a specific disorder?

_____

_____

Has your child received any special education, early intervention services or special therapy?

_____

_____

Present Communication Profile

Which of the following best describes your child's speech? (check all that apply)

Easy to understand ___ Difficult for others to understand ___ Almost never understood by others ___

Does your child have trouble producing certain sounds? No ___ Yes ___

If yes, which ones _____

Does your child hesitate and/or repeat sounds or words? No ___ Yes ___

Does your child "get stuck" when attempting to say a word? No ___ Yes ___

What languages does your child speak? _____

What languages does your child understand? _____

What is your child's primary language? _____

What languages are spoken in your home? _____

What is the primary language spoken at home? _____

Education

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

_____

_____

How did your child adapt to the first day(s) at school or preschool?

Mostly positive ___ Mixed ___ Mostly Negative ___ N/A ___ How old was he/she? _____

How much time did your child attend per week? _____

Behavior/Character

How would you describe your child?

_____

_____

What are your child's strengths and weaknesses

_____

_____

What is your greatest concern regarding your child's communication?

_____

_____

Have there been any specific behavior problems in the course of your child's development?

_____

_____

What kind of interests and activities does your child have? (ie hobbies, sports, clubs) Please list them in order of preference beginning with the favorite activity.

_____

_____

How would you describe your child's social adjustment?

With peers? _____

With adults? _____