

<b>Pediatric</b>	Name: _____
<b>History and Background Information</b>	Date: _____
<b>Past Medical History</b>	D.O.B: _____

Was the childbirth normal or were there complications \_\_\_\_\_

If any complications, please list

<b>Etiologies</b>	<b>Yes</b>	<b>No</b>	<b>Notes</b>
Anoxia			
Breathing difficulties			
Cranial Facial (cleft lip or palate)			
Failed Hearing screening			
Premature			
Other _____			

Was your child hospitalized, if so, for what \_\_\_\_\_

\_\_\_\_\_

What is the primary language at home \_\_\_\_\_

What is the primary language your child speaks, if they do not speak how do they communicate \_\_\_\_\_

	<b>Yes</b>	<b>No</b>	<b>Notes</b>
Gesture			
Point			
Short Phrases			
Sign			
Use a PEC System			
Vocalizations			
Words			
Other _____			

Please list the approximate age your child achieved the following developmental milestones

Babbled \_\_\_\_\_

Said first word \_\_\_\_\_

Put two words together \_\_\_\_\_

Spoke in short sentences \_\_\_\_\_



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<b>Past Medical History continued</b>	D.O.B: _____

	Yes	No	Notes
If they do speak, do they use the following			
Sounds			
Words			
2-4 Word Sentences			
Other _____			

What language does your child understand \_\_\_\_\_

What is the primary concern for your child \_\_\_\_\_

Is your child receiving any therapy for their communication delay or other delays (like physical or occupational) if so, what \_\_\_\_\_

Is their vision and hearing functional \_\_\_\_\_

If there is a hearing loss, are they aided \_\_\_\_\_

Do they have a Cochlear Implant, if so, when were they implanted \_\_\_\_\_

Is there a history of heart problems \_\_\_\_\_

Is there a history of respiratory problems \_\_\_\_\_

**Speech an Language Ages 0-3**

Is your child able to follow simple directions at home involving familiar items, do they need repetition

	Yes	No	Notes
1 Step			
2 Step			
3 Step			

Can your child go into another room and retrieve an item when asked \_\_\_\_\_



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### Speech and Language Ages 0-3

Can your child answer simple: What, Where, and Who questions \_\_\_\_\_

Is your child able to predict routines from what you say:

	Yes	No	Notes
"Time for Bed"	<input type="checkbox"/>	<input type="checkbox"/>	
"Snack Time"	<input type="checkbox"/>	<input type="checkbox"/>	
"Time to clean up"	<input type="checkbox"/>	<input type="checkbox"/>	

Does your child recognize signs such as :

	Yes	No	Notes
Burger King	<input type="checkbox"/>	<input type="checkbox"/>	
Walmart	<input type="checkbox"/>	<input type="checkbox"/>	
McDonald's	<input type="checkbox"/>	<input type="checkbox"/>	
Dunkin' Doughnuts	<input type="checkbox"/>	<input type="checkbox"/>	

Does your child like to sing, dance, or listen to music \_\_\_\_\_

How many words do they have

	Yes	No	Notes
12-18 months; 3-20 words	<input type="checkbox"/>	<input type="checkbox"/>	
18-24 months; 50 words	<input type="checkbox"/>	<input type="checkbox"/>	
24-30 months; 200 words	<input type="checkbox"/>	<input type="checkbox"/>	
30-36 months; 500 words	<input type="checkbox"/>	<input type="checkbox"/>	

If your child speaks, do they omit sounds \_\_\_\_\_

Is their speech intelligible, please rate it

	Yes	No	Notes
100%	<input type="checkbox"/>	<input type="checkbox"/>	
70%	<input type="checkbox"/>	<input type="checkbox"/>	
50%	<input type="checkbox"/>	<input type="checkbox"/>	
25%	<input type="checkbox"/>	<input type="checkbox"/>	
0%	<input type="checkbox"/>	<input type="checkbox"/>	



