

SPEECH AND HEARING CLINIC  
 THE PENNSYLVANIA STATE UNIVERSITY  
 110 FORD BUILDING; UNIVERSITY PARK, PA 16802  
 V / TDD# (814) 865-5414  
 Fax: (814) 863-3759

CHILD THERAPY PROGRAM  
 Child History Information

In preparation for your child’s speech / language assessment, please answer the questions below. You may wish to consult several sources (baby book, medical records, etc.). **This information is for confidential use and will aid us in planning and coordinating a more thorough evaluation.**

*Cost of the assessment is \$75.00, which includes the assessment, the follow-up meeting to discuss assessment results and recommendations, and a written report. Payment should be made the day of the assessment. With the exception of Geisinger Health Plan (GHP), the Speech and Hearing Clinic does not bill insurance companies, primarily because insurance companies in general do not reimburse for this service. You will be provided with a copy of the billing sheet(s) that includes the fee paid, the diagnosis and the code for that diagnosis. You can submit that to your insurance company if you wish to pursue reimbursement.*

***If you are covered by GHP, prior to the assessment, you will need to ask your physician for a referral for a speech / language evaluation. The referral and insurance card need to be provided to Dawn Williams, at the Speech and Hearing Clinic, at least two weeks prior to the assessment to receive authorization prior to service. In care of Dawn Williams, they can be faxed to [814-863-3759](tel:814-863-3759), emailed to [ddw16@psu.edu](mailto:ddw16@psu.edu), dropped off at 110 Ford Building or mailed to 110 Ford Building, University Park, PA 16802. We will bill GHP directly. It is likely that your GHP policy will require a co-pay, which would be paid at the time of the assessment.***

After answering the questions, please return the form in the enclosed envelope. When we receive all forms, we will contact you about a specific appointment date. Thank you.

Date: \_\_\_\_\_

Person to be evaluated

Name:	Date of Birth:
Parent(s) Names:	
Address:	Present Age:
	Sex:
Phone number:	Nickname:
Email address:	Grade:
Cell phone number:	School:

Family Information / People with Whom the Child Lives

Father's Name and Age:	Occupation:
Mother's Name and Age:	Occupation:
Siblings Names and Ages:	
Others in the household:	

List significant activities, interests, events, hobbies, favorite toys, etc. for this child.

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Who typically takes care of your child?

Daycare \_\_\_\_\_ Frequency and Duration \_\_\_\_\_  
Preschool \_\_\_\_\_ Frequency and Duration \_\_\_\_\_

With whom does the child live?

Name:	Address:
Phone number:	

Person filling out this form

Name:	Relation:
Address:	Phone:

Child referred by

Name:	Relation:
Address:	Phone:
Reason for Referral:	

Statement of Concern (Please describe your child’s speech and language as fully as possible):

1. When was this concern first noticed? \_\_\_\_\_  
By whom? \_\_\_\_\_
2. What do you hope to learn from this evaluation? \_\_\_\_\_
3. Why are you seeking services at the Penn State Speech and Hearing Clinic at this time? \_\_\_\_\_

Please list other family member(s) who have a hearing loss (before age 50) or speech/language or learning difficulties (brothers, sisters, mother, father, and extended family such as grandparents, cousins, etc.):

**Prenatal (pregnancy), Birth, and Development**

**1. Prenatal**

Mother’s age when child was born \_\_\_\_\_ Father’s age when child was born \_\_\_\_\_  
 Length of pregnancy in weeks \_\_\_\_\_  
 Birth weight \_\_\_\_\_ One minute Apgar \_\_\_\_\_ Five minute Apgar \_\_\_\_\_  
 How long was the infant’s stay in the hospital following birth? \_\_\_\_\_

Yes	No	<i>If any questions are answered “yes”, please provide additional information below.</i>
		Did the mother experience bleeding during pregnancy?
		Did the mother have measles during pregnancy?
		Did the mother have high blood pressure during pregnancy?
		Did the mother experience leakage of membranes during pregnancy?
		Were there complications (e.g., anemia, dehydration, diabetes, kidney infection, severe nausea, toxemia, accidents, etc.) during this pregnancy?
		Were prescription/non-prescription drugs (including alcohol) taken during pregnancy?

## 2. Birth

Yes	No	<i>Other than the 1<sup>st</sup> question, if any questions are answered "yes", please provide additional information below.</i>
		Did the mother have a vaginal delivery with this child?
		Did the mother have a breech delivery?
		Did the mother have a Caesarean Section delivery?
		Were there birth injuries?
		Were there breathing difficulties (e.g., blue baby, required oxygen, stopped breathing, apnea, other _____)
		Were special instruments used during delivery?
		Was the baby jaundiced at birth?
		Was there Rh incompatibility?
		Were there any problems or complications following birth or during the first two weeks of your infant's life (feeding, seizures, sleeping, swallowing, hospitalizations, etc.)?

## 3. Development (give age when first occurred)

Age	Motor Skill	Age	Motor Skill
	Held head up		Fed self with spoon
	Sat up unsupported		Bladder Trained
	Reached for object		Bowel trained
	Crawled		Dressed Self
	Stood alone		Undressed Self
	Walked alone		

What motor &/or self-help development concerns do you have for this child? \_\_\_\_\_

Would you describe your child's coordination as: \_\_\_\_ good \_\_\_\_ fair \_\_\_\_ poor

Explain: \_\_\_\_\_

## Child's Medical History

Child's pediatrician / primary care physician

Name:	Address:
Phone number:	

Please check all conditions that your child has had or presently has:

### General

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> allergies       | <input type="checkbox"/> asthma            | <input type="checkbox"/> blood disease              |
| <input type="checkbox"/> chicken pox     | <input type="checkbox"/> convulsions       | <input type="checkbox"/> crossed eyes               |
| <input type="checkbox"/> croup           | <input type="checkbox"/> dental problems   | <input type="checkbox"/> diphtheria                 |
| <input type="checkbox"/> encephalitis    | <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> apraxia                    |
| <input type="checkbox"/> headaches       | <input type="checkbox"/> head injury       | <input type="checkbox"/> dysarthria                 |
| <input type="checkbox"/> heart problems  | <input type="checkbox"/> high fevers       | <input type="checkbox"/> influenza                  |
| <input type="checkbox"/> measles         | <input type="checkbox"/> meningitis        | <input type="checkbox"/> mumps                      |
| <input type="checkbox"/> muscle disorder | <input type="checkbox"/> nerve disorder    | <input type="checkbox"/> traumatic brain injury     |
| <input type="checkbox"/> pneumonia       | <input type="checkbox"/> polio             | <input type="checkbox"/> bronchopulmonary dysplasia |

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> rheumatic fever                  | <input type="checkbox"/> cerebral palsy        | <input type="checkbox"/> tracheostomy          |
| <input type="checkbox"/> whooping cough                   | <input type="checkbox"/> stroke                | <input type="checkbox"/> RSV                   |
| <input type="checkbox"/> neonatal drug dependence         | <input type="checkbox"/> failure to thrive     | <input type="checkbox"/> CMV (Cytomegalovirus) |
| <input type="checkbox"/> fetal alcohol syndrome           | <input type="checkbox"/> feeding or swallowing | <input type="checkbox"/> HIV                   |
| <input type="checkbox"/> gastroesophageal reflux problems |  |  |
| <input type="checkbox"/> Others (list below)              |  |  |
- 
- 

**Child’s Visual Status**

- Does your child wear glasses?  yes  no
- Does your child have any visual problems?  yes  no If so, describe, including any accommodations necessary within the classroom: \_\_\_\_\_  
\_\_\_\_\_
- Date of most recent vision testing \_\_\_\_\_
- Where was the testing done? \_\_\_\_\_
- By whom was the testing performed? \_\_\_\_\_

**Ear, Nose, and Throat**

Please check all conditions that your child has had or presently has:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> chronic cough/colds  | <input type="checkbox"/> hoarse voice                | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> tonsillitis          | <input type="checkbox"/> tonsillectomy               | <input type="checkbox"/> adenoidectomy         |
| <input type="checkbox"/> tongue deformity     | <input type="checkbox"/> jaw deformity               | <input type="checkbox"/> cleft palate/lip      |
| <input type="checkbox"/> speech problem       | <input type="checkbox"/> ear deformity               | <input type="checkbox"/> dizziness             |
| <input type="checkbox"/> too much wax in ears | <input type="checkbox"/> pressure equalization tubes |  |

Please list any medications the child is taking presently: \_\_\_\_\_  
\_\_\_\_\_

If your child has been seen by a medical specialist, hospital, clinic, agency, etc., please list below:

Agency/Specialist \_\_\_\_\_ Date \_\_\_\_\_  
 What was done? \_\_\_\_\_  
 Results/Recommendation \_\_\_\_\_

**Child’s Communication Skills**

Speech Production: Check and provide examples / descriptions where applicable

	Sounds are not produced at all (e.g., “look” is pronounced as “ook”)
	Sounds are substituted for with other sounds (e.g., “cat” is pronounced as “tat”)
	Sounds are not produced clearly (e.g., “s” sounds slushy)

Expressive Language: Check and provide examples descriptions where applicable

Yes	No	<i>If any questions are answered "yes", please provide additional information.</i>
		Are languages other than English (including sign language) used at home?
		Did the child begin to babble or talk and then stop?
		Child is not talking, but may be using gestures.
		Child is only saying a few words.
		Child is talking, but only puts a few words together at a time.
		Child is talking, but there are errors in grammar.

1. Please indicate all means of communication currently used:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Speech                            | <input type="checkbox"/> Vocalizations     | <input type="checkbox"/> Bodily Gestures      |
| <input type="checkbox"/> Facial Gestures                   | <input type="checkbox"/> Gestural (yes/no) | <input type="checkbox"/> Takes person to item |
| <input type="checkbox"/> Spoken (yes/no)                   | <input type="checkbox"/> Manual Signs      | <input type="checkbox"/> Pointing             |
| <input type="checkbox"/> Augmentative Communication Device |  |   |

List any adaptive equipment currently used and describe your child's ability to communicate with the device:

\_\_\_\_\_

\_\_\_\_\_

2. At what age did your child say his/her first word? \_\_\_\_\_  
 What were the child's first few words? \_\_\_\_\_

3. Approximately how many words did the child have at  
 18 months? \_\_\_\_\_ 24 months? \_\_\_\_\_

4. At what age did the child say his/her first sentence? \_\_\_\_\_  
 Please give some examples of first sentences: \_\_\_\_\_  
 Please give some examples of phrases/ sentences your child typically uses now: \_\_\_\_\_

5. How often does your child use speech?  Frequently  Sometimes  Rarely

6. How does your child make his/her needs known? \_\_\_\_\_

7. Does the child use gestures often?  yes  no if so, give an example \_\_\_\_\_

8. What does the child use the most?  
 Gestures  Sounds  One or two words  Phrases  Complete sentences

9. Estimate the percentage of time that the child is understood by:  
 Unfamiliar listeners  Parents  Other adults  Brothers and Sisters  Friends

Receptive Language: Check and provide examples descriptions where applicable

11. How well does the child understand what is said to him/her? \_\_\_\_\_

	Understands gestures
	Does not understand spoken words
	Understands single words

	Understands simple sentences
	Understands / follows 1 step directions
	Understands / follows 2 step directions
	Understands / follows 3 step directions
	Understands conversation

Voice: Check and provide examples descriptions where applicable

	Voice sounds consistently hoarse
	Voice sounds like child has a cold
	Voice sounds like child is talking through his / her nose

Fluency: Check and provide examples descriptions where applicable

	Child repeats sounds or words when talking
	Child has trouble getting the sentence started
	Child has changes in pitch when having trouble talking
	Child shows signs of awareness of his/her difficulty talking
	Child has tension, facial grimaces, etc.

Do you think the child is aware of his/her communication difference? \_\_\_ yes \_\_\_ no

If yes, please describe how the child shows awareness. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Provide any other information about your child's communication that is of concern to you.

\_\_\_\_\_  
 \_\_\_\_\_

What have immediate family and/or relatives done to help the child overcome his/her communication difficulty?

\_\_\_\_\_  
 \_\_\_\_\_

Has this helped? \_\_\_\_\_

What do you think caused this communication difference? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please provide any additional information you feel will help us in understanding the child and his/her present communication ability. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Child's Hearing Status**

Date of most recent hearing evaluation \_\_\_\_\_ Results \_\_\_\_\_  
 Where was testing performed? \_\_\_\_\_  
 By Whom? \_\_\_\_\_

Yes	No	
		Do you feel that the child hears well?
		Has the child ever been exposed to a loud noise or explosion?
		Has the child ever had an ear infection? If so, which ear? Last occurrence _____ First occurrence _____ Frequency _____
		Does the child presently have or in the past had draining ears (pus, blood, etc.)?
		Does the child ever complain of ear noises (tinnitus) such as ringing, buzzing, pulsing, etc.?
		Is the child able to locate the direction from which sound is coming?
		Does your child hear the same from day to day?
		Does your child favor one ear? If so, which ear?
		Does your child respond to vibration caused by loud sounds (door slam, truck driving by, airplane, radio in car, boom box vibration, etc.)?
		Does your child watch the speaker's face when listening?
		Does your child wear hearing aids? Right ear _____ Left ear _____ Both ears _____ Make and Model _____ How long has he/she worn hearing aids? _____ How many hours a day does your child wear the hearing aids? _____

**Child's Educational History**

Does your child attend \_\_\_ day care \_\_\_ kindergarten \_\_\_ school \_\_\_ other

Name of School	
Current Grade	
Type of Class	(e.g., regular education classroom, FT learning support classroom, autism classroom, etc.)
Address	
Phone	
Teacher	
Speech Language Pathologist	
Name of Principal	



Previous Schools Attended:

Name of School	Address	Dates Attended

Current grades for: Reading \_\_\_\_ Language \_\_\_\_ Spelling \_\_\_\_ Math \_\_\_\_

**Child's Cognitive History**

Psychological Evaluation Completed: \_\_\_\_\_

Date of most recent test: \_\_\_\_\_ Where tested: \_\_\_\_\_

By Whom? \_\_\_\_\_ Test Results and Recommendations: \_\_\_\_\_

\_\_\_\_\_

\*Please provide us with a copy of the Evaluation Report.

**Other Services Currently or Previously Provided**

Has your child been evaluated by another professional?

Type of Evaluation Completed: \_\_\_\_\_

Date of most recent test: \_\_\_\_\_ Where tested: \_\_\_\_\_

By Whom? \_\_\_\_\_ Test Results and Recommendations: \_\_\_\_\_

\_\_\_\_\_

\*Please provide us with a copy of the Evaluation Report.

Type of Evaluation Completed: \_\_\_\_\_

Date of most recent test: \_\_\_\_\_ Where tested: \_\_\_\_\_

By Whom? \_\_\_\_\_ Test Results and Recommendations: \_\_\_\_\_

\_\_\_\_\_

\*Please provide us with a copy of the Evaluation Report.

Does your child have a current IEP? \_\_\_ Yes \_\_\_ No

If yes, please send a copy to this clinic.

What goals have been targeted in your child's IEP?
What progress have you observed?
What factors do you think have contributed to progress / lack of progress?

Do you have the opportunity to observe your child's therapy sessions?

Do you receive "homework" to practice with your child?

If so, describe the practice sessions.