



BACKGROUND HISTORY FORM

Child's Name _____ Birth Date _____ Today's Date _____

Age _____ Parents/Guardians Full Names _____

Siblings and Ages _____

Primary Language Spoken In the Home _____ Other Languages _____

Referred By _____

Person Completing this Form _____ Relationship to Child _____

Birth Information (Check All Those That Apply)

Complications/Health Problems During Pregnancy:

Diabetes _____ Measles _____ Toxemia _____ Premature Labor _____ Strep _____ Respiratory _____

Other _____

Complications During Labor/Delivery

Cesarean Section _____ Emergency? Y N Forceps _____ Vacuum _____ Other _____

Medications Given During Delivery _____

Describe Child's Condition At/Or Immediately After Birth:

Premature _____ (If Yes) Gestational Age _____ Apgars _____ NICU _____ (If Yes) How Long? _____

Ventilator _____ (If Yes) How Long? _____ Jaundice _____ Heart Problems _____ Poor Suck _____

Small For Gestational Age _____ Large For Gestational Age _____

Known Diagnosis (e.g. Down Syndrome) _____

Other Medical Complications _____

Child's Medical History:

Measles _____ Mumps _____ Pneumonia _____ Chicken Pox _____ Bronchitis _____ BPD _____

Reflux _____ Allergies _____ Head Injuries _____ Tonsillitis _____ Other _____

Ear Infections _____ Frequency _____ Last Ear Infection _____

Treatment Method _____

List Any Hospitalizations:

Dates (from ___ to ___)	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Any Surgery Performed:

Ear Tubes _____ Still In Place? _____ Central Line _____ Spinal Infusions _____ G-Tube _____
Heart Repair _____ Trach _____ Shunt _____ Tonsillectomy _____ Appendectomy _____
Other _____

Tests Performed:

MRI _____ CT Scan _____ Genetic Testing _____ X-Rays _____ Other _____

Please List Current Medications: _____

Has The Child Had Any Seizures? Y or N Please Describe And Indicate Frequency _____

Child's Developmental History:

Developmental Milestones:

Please List The Approximate Age The Child Accomplished The Following:

Lift Head While On Tummy _____ Rolled Over _____ Sat Without Support _____ Crawled _____
Stood Alone _____ Walked Alone _____ Dress/Undress Self _____ Button/Zip Clothes _____
Started Solid Foods _____ Held Cup _____ Used Fork _____ Drank From: Sippy Cup _____ Open Cup _____
Dry During Day _____ Dry At Night _____ Gain Bowel Control _____ Hand Preference: L R
Does Your Child Have Any Bowel Or Bladder Difficulties? Please Describe _____

Speech:

Please List The Approximate Age The Child Accomplished The Following:

Babble (dada, baba, etc.) _____ Said First Words _____ Combined Words _____
Does Your Child Respond When His/Her Name Is Called? Y N Follow Simple Directions? Y N
Approximately How Many Words Does Your Child Have? _____
How Does Your Child Tell You What He/She Wants? _____

Check Any Areas of Concern Regarding Speech and Language:

Length of Statements Your Child Uses _____ Ability to Produce Sounds Correctly _____
Ability to Find the Right Word (i.e., I want that, uh, thing that, uh, goes around) _____

Fluency of Speech (e.g., I-I-I will go to-to-to-to school now.) _____
Quality of Voice (e.g., nasal, hoarse, pitch) _____ Ability to Sustain Attention _____
Ability to Stay on Topic _____ Ability to Initiate a Topic _____
Ability to Establish Peer Relationships _____ Ability to Follow Directions _____
When Did You First Notice Difficulties with Your Child's Speech and Language? _____
Does Your Child Become Frustrated Due to These Difficulties? _____
Family History of Speech and Language Difficulties? Please Describe _____

Feeding:

Does Child Have Any Feeding Difficulty With The Following:
Poor Suck _____ Difficulty Swallowing _____ Difficulty Chewing _____ Gag/Choke Often _____
Finger Feeding _____ Spoon Use _____ Required A Feeding Tube _____ Reflux/Vomiting _____
List Any Other Feeding Concerns _____
Is Your Child a Picky Eater? Y N Does Your Child Dislike Particular Textures of Food? Y N
What is Your Child's Favorite Food? _____ Least Favorite Food? _____

Hearing/Vision:

Has Your Child Ever Had A Vision Test? Y N If Yes, Date Last Performed _____
Results _____
Does Your Child Wear Glasses? Y N
Has Your Child Ever Had A Hearing Test? Y N If Yes, Date Last Performed _____
Results _____
Does Your Child Wear A Hearing Aide? Y N If Yes, Please Indicate L R

Sensory History:

Does Your Child's Hands, Feet, And/Or Tummy Seem Overly Sensitive To Touch? Y N
Does Your Child Seem Distractible Or Overactive? Y N If Yes, Please Describe _____

Does Your Child Tolerate Toothbrushing? Y N

Educational History:

What School Does Your Child Attend? _____ Current Grade Level _____
How Often Does He/She Attend School? _____ days per week _____ hours per day
What Are Your Child's Strengths in School? _____
What Areas at School Are Most Difficult for Your Child? _____

Additional Information:

Please List Any Behavioral Issues _____

Please Explain Why You Want This Evaluation Done _____

Has Your Child Had Any Previous Evaluations/Therapy? Y N

If Yes, Please Provide Dates, Facility Where Performed, Type Of Therapy And Reason(s) _____

Please List Any Pertinent Family Medical History _____

Is There Anything Else That You Would Like Us To Know About Your Child? _____

Thank you for taking the time to complete this form. The information you provided is valuable in assessing your child's skills.

Please List The Doctors Who Are Involved In The Care Of Your Child:

Pediatrician Or Family Doctor:

Name _____
Address _____
Phone _____

Orthopedist:

Name _____
Address _____
Phone _____

Neurologist:

Name _____
Address _____
Phone _____

Cardiologist:

Name _____
Address _____
Phone _____

Eye Doctor:

Name _____
Address _____
Phone _____

Ear Doctor:

Name _____
Address _____
Phone _____

Other Specialist: (Please List Type _____)

Name _____
Address _____
Phone _____

Other Specialist: (Please List Type _____)

Name _____
Address _____
Phone _____