NORTHEAST OUTPATIENT REHAB CENTER – AUDIOLOGY & SPEECH DEPARTMENT
130 LAKE CONCORD ROAD, CONCORD, NC 28025 704-783-1472

CHILD HISTORY QUESTIONNAIRE TODAY'S DATE_____

Name: _____

Address: _____

Phone: _____

REFERRAL INFORMATION:

1) Who referred you here? _____
2) What is your main concern regarding your child's speech? Please describe the problem _____
   _____
3) Who first noticed the problem? _____
4) How old was your child when the problem began? _____
5) What do you feel is the reason for the problem? _____
   _____

FAMILY/SCHOOL INFORMATION:

6) The child lives with: mother____ father____ grandparents _____ siblings (please list names & ages
   _____
7) Does your child attend school or daycare? _____ If yes, which one? _____
   What days and hours: _____
   Grade or level: _____
8) Primary language spoken at home _____
9) Is the child receiving any therapy at this time? _____ If yes, where and what kind? _____
   _____
   When did treatment start? _____
10) Has the child had any other speech/language or related testing done (occupational, physical, psychological)? _____ If yes, where and when _____
    What were the results? _____
11) Is there any one in the family who has/had speech, hearing or learning difficulties (who and what kind)? _____

MEDICAL INFORMATION:

12) Who is your child's pediatrician? (If at a clinic, which pediatrician?) _____
13) Is your child current with his/her immunizations? _____
14) How is your child's vision?_____ Does he/she wear glasses? _____ Has he/she had their vision tested? _____
15) How is your child's hearing?_____Does he/she wear a hearing aid?____Which ear?_____
16) Has his/her hearing been tested (where & when)? _____
    What were the results?_____
    Do you feel that your child could benefit from further hearing testing?_____
17) Does your child have or has he/she ever had PE tubes (in the ears)?_____
    If yes, where and when?_____

If PE tubes were inserted, are they still in place? _____

18) Has your child been hospitalized for any reason? Please explain._____
_____

19) Does your child have a history of: ear infections _____ high fever _____feeding problems _____ croup _____allergies (to what) _____ tonsillitis ____ _____ meningitis _____seizures _____asthma _____ chronic colds _____surgery (for what) _____

20) Does your child have a medical diagnosis (what)? _____

DEVELOPMENTAL HISTORY

21) Were there any complications during pregnancy? (Describe) _____

22) Were there any complications immediately following birth? (Describe) _____
_____

23) At what age did your child first crawl:_____take first steps _____say first words_____ _____Combine words_____

24) Did your child babble?_____Slow down or stop talking? _____ Regress?_____

Feeding History

25) Did your child have any difficulties feeding after birth?_____ If yes, please describe _____
_____

26) Is your child a picky eater? _____
_____

27) Is your child a messy eater for his/her age? _____

28) What foods does your child typically eat for snacks and meals?_____
_____

29) When did your child stop using a bottle?_____

30) When did your child use a pacifier?_____ Does he/she still?_____Does your child us a sippy cup? _____

PLAY/SOCIAL INFORMATION

31) Does your child play appropriately with toys?_____If not, please explain_____
_____

32) Does your child engage in any odd behaviors?_____ If yes, please explain _____
_____

33) Does your child have difficulty concentrating?_____

34) Does your child have any problems with behavior?_____
_____If yes, please explain_____

35) Is your child exceptionally active?_____

SENSORY/MOTOR DEVELOPMENT

36) Does your child appear awkward or clumsy?_____ If yes, explain _____

37) Does your child seem averse to certain types of textures (examples: does not like getting dressed, hates tags in clothes, does not like water?)_____If yes, explain_____

38) Does your child seem to shy away from trying new activities?_____ If yes, explain_____
_____

Your Name:_____

Relationship to child:_____

Carolinas Medical Center
NorthEast
920 Church St., North-Concord, NC 28025

OUTPATIENT REHAB CENTER
AUDIOLOGY & SPEECH DEPARTMENT
CHILD HISTORY QUESTIONNAIRE

DOS: DOB: // Sex:
Age: Race: Serv.Type: Visit Type: Loc: Rm:
Attend. Phy:

REH0042 (Rev. 08/05) Rehabilitation