Speech Leaps LLC
1858 Smallwood Road
Ridgeway, South Carolina 29130
Phone: (803) 553-0813
Fax: (803) 787-0507
Email: speechleapssc@gmail.com

Social, Health, and Developmental History

Child's Full Name _____ Date of Birth_____ Race_____
Mailing Address_____ Street_____
Home Phone #_____ Cell Phone #_____ Work #_____
Social Security Number_____ Grade_____

SOCIAL

MOTHER / FEMALE GUARDIAN IN HOME
Name_____
Relationship to Child_____
Age_____ Marital Status_____
Level of Education Completed_____
Occupation_____
Employer_____

FATHER / MALE GUARDIAN IN HOME
Name_____
Relationship to Child_____
Age_____ Marital Status_____
Level of Education Completed_____
Occupation_____
Employer_____

LIST PARENTS NOT LIVING IN THE HOME

Name	Relationship	Contact/Involvement with Child

LIST BROTHERS AND SISTERS (Attach additional page if necessary.)

Name	Age	Sex	Living in home?
			Yes No
			Yes No
			Yes No
			Yes No

LIST OTHER PERSONS WHO ARE CURRENTLY LIVING IN THE HOME NOT NAMED ABOVE

Name	Age	Sex	Relationship

Have any of the child's biological parents, grandparents, and / or siblings ever received rehabilitative services?
( ) Yes ( ) No If yes, please explain._____
_____

What is the primary language spoken in the home? ___ English Other_____

What is the patient's primary language? ___ English Other_____

How does your child get along with others at home?_____

HEALTH

Did the mother receive prenatal care from a physician? ( ) Yes ( ) No

Did the mother experience any of the following during pregnancy or delivery?

___ High blood pressure
___ Toxemia
___ RH incompatibility
___ Measles
___ Gestational diabetes
___ Anemia
___ Excessive vomiting
___ Physical injury
___ Use of forceps during delivery
___ Illness
___ Use of tobacco products
___ Use of alcohol
___ Use of illicit drugs (marijuana, cocaine, etc.) _____
___Prescribed medication_____
Other _____

Was the baby born prematurely? ( ) Yes ( ) No If yes, how many weeks premature?_____

What was the baby's weight at birth? _____ pounds _____ ounces

Did the baby experience any complications at birth?

___ Lengthy hospital stay
___ Physical defects
___ Breathing problems
___ Oxygen deprivation
___ Heart problems
___ Use of incubator
___ Use of forceps during delivery
___ Other_____

List any prescription medications which your child is currently taking.

Name of Medication	*Dosage*	*Purpose*
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is the name and city of your child's physician?_____

Please check all that apply to your child. For those checked, **please provide the date or age at which it occurred or began.**

___ Head injury_____
___ Seizures_____
___ Coma_____
___ Stroke_____
___ Cerebral palsy_____
___ Meningitis_____
___ Encephalitis_____
___ Brain tumor_____
___ Shaken Baby Syndrome_____
___ Migraine_____
___ Fetal Alcohol Syndrome_____
___ Lead poisoning_____
___ Cancer_____
___ Cystic Fibrosis_____
___ Tuberculosis_____
___ Fever of 104 or higher_____
___ Frequent ear infections_____
___ Allergies_____
___ Hearing problems_____
___ Vision problems_____
___ Asthma / Respiratory problems_____
___ Heart problems_____
___ Digestive problems_____
___ Rheumatic Fever_____
___ Measles_____
___ Complications from chicken pox_____
___ Emotional/Behavioral problems_____
___ Other_____

Has your child ever had a hearing screening or evaluation? Please include date and results.

_____

_____

How would you describe your child's present health? ( ) Poor ( ) Fair ( ) Good ( ) Excellent

Typically, how many hours per night does your child sleep?_____

Does your child have any sleep problems or disorders (exs. sleep apnea, night terrors, sleep walking, difficulty going to or staying asleep)?_____

Feeding

Does you child experience any difficulties with swallowing/feeding? _____
If so, please describe:

_____

_____

What type of foods does your child eat? (ex: Stage 1 baby food, liquid diet, regular table foods)

_____

What type of liquids does your child drink? (ex: regular, thickened, etc.)

Has your child ever had a Modified Barium Swallow performed to assess swallowing difficulties? _____
If so, when? _____ What were the results?

_____

DEVELOPMENTAL

Place a check beside any area in which your child had significant difficulty as an infant and/or toddler.

___ Feeding ___ Motor skills ___ Weight / Failure to thrive ___ Excessive crying
___ Separating from parents ___ Temper tantrums ___ Being held / affection

LANGUAGE DEVELOPMENT

1. At what age did your child say his/her first words?_____ Put words together?_____
2. What were your child's first words?_____
3. Does your child appear to hear well? ( ) Yes ( ) No _____
4. Does your child follow directions given orally? ( ) Yes ( ) No _____
5. Do you think your child has a speech or language problem? ( ) Yes ( ) No _____
6. Does your child appear to be aware of any differences in his/her speech? ( ) Yes ( ) No If yes, how does he/she react?
   _____
7. Has your child ever been evaluated by or received speech-language therapy from any other agency or individual?
   ( ) Yes ( ) No
   If yes, by whom?_____
8. Are there any known conditions affecting his/her tongue, palate, nose, throat, vocal cords, or ears (i.e. cleft palate, vocal nodules, etc.?) ( ) Yes ( ) No _____
9. When did you first become concerned about your child's communication skills?_____

_____

What are your child's strengths ?_____

What are your child's weaknesses?_____

The information you have reported on this form may be used to plan and conduct an evaluation of your child. Is there any other information which you feel should be considered?_____

_____

Completed By _____ Date_____