HealthCare
KENTUCKY CHILDREN'S HOSPITAL

UNIVERSITY OF KENTUCKY
DIVISION OF COMMUNICATION DISORDERS

SPEECH LANGUAGE EVALUATION HISTORY FORM

Medical Record # _____

I. GENERAL INFORMATION

Child's Name: _____ Today's Date: _____

Birth Date: _____ Child's Age: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Father's Name: _____ Age: _____ Education: _____

Occupation: _____ Phone: _____

Email: _____

Mother's Name: _____ Age: _____ Education: _____

Occupation: _____ Phone: _____

Email: _____

Family Physician: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Description of Problem (Reason for coming to our clinic): _____

_____

_____

_____

_____

Brothers and Sisters (include names and ages): _____

_____

Describe any speech, hearing or language problems in the family: _____

_____

_____

II. LANGUAGE SPOKEN IN THE HOME

Is there a language other than English spoken in the home? ◉ Yes ○ No

Does the child speak the language? ◉ Yes ○ No

Does the child understand the language? ◉ Yes No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

III. BIRTH HISTORY

Mother's general health during pregnancy (including accidents and illnesses): _____

_____

_____

Length of Pregnancy: _____ Birth Weight: _____ lbs. _____ oz.

Length of Labor: _____ Medications: _____

Age of Mother at Birth: _____ Age of Father: _____

Birth difficulties and /or injuries: _____

_____

Delivery: (circle one) Head First ○ Feet First ○ Caesarean ○ Breach ○

Feeding Problems: _____

IV. MEDICAL HISTORY (Fill in approximate age as well as number of incidents)

_____	Tonsillitis	_____	Strep Throat
_____	Ear Discharge	_____	Hearing Problems
_____	Measles	_____	Earaches
_____	Pneumonia	_____	Paralysis
_____	Whooping Cough	_____	Mumps
_____	Seizures / Convulsions		

Hearing test: (circle one) Yes ○ No ○ When: _____

Where: _____

Results: _____

(**Please also provide hearing test results if applicable**)

Other: _____

Accidents: _____

Operations: _____

Medical Diagnosis: _____

Medications: _____ Allergies: _____

V. DEVELOPMENTAL HISTORY (Fill in appropriate age)

Crawling: _____ Sitting: _____ Standing: _____

Walking: _____ Feeding Self: _____ Dressing Self: _____

Completely Toilet Trained: _____ Hand Preference: _____

Does he/she have any difficulty walking, running or throwing? (Describe): _____

_____

Other Developmental Problems: _____

_____

Does he/she use assistive equipment (i.e., wheelchair, hearing aids, etc. Please specify): _____

_____

_____

VI. SPEECH, HEARING AND LANGUAGE BEHAVIOR

(Please fill in Yes or No with the Appropriate Age)

Did child babble / coo: _____ Used first single words: _____

Combined words: _____

Does child understand gestures: _____ Speech: _____

Does child use words to make his needs known? _____

Gestures: _____

What was your first indication that a problem existed? _____

_____

Give place and date of any previous speech/language, educational, psychological or hearing test: (Please attach reports if available): _____

_____

VII. CURRENT SPEECH-LANUAGE-HEARING

Does your child…

- ○ repeat sounds, words or phrases over and over?
- ○ understand what you are saying?
- ○ retrieve/point to common objects upon request (ball, cup, shoe)?
- ○ follow simple directions ("Shut the door" or "Get your shoes")?
- ○ respond correctly to yes/no questions?
- ○ respond correctly to who/what/where/when/why questions?

Your child currently communicates using…

- ○ body language.
- ○ sounds (vowels, grunting).
- ○ words (shoes, doggy, up).
- ○ 2 to 4 word sentences.
- ○ sentences longer than four words.
- ○ other _____.

Behavioral Characteristics:

- ○ cooperative
- ○ attentive
- ○ willing to try new activities
- ○ plays alone for reasonable length of time
- ○ separation difficulties
- ○ easily frustrated/impulsive
- ○ stubborn
- ○ restless
- ○ poor eye contact
- ○ easily distracted/short attention
- ○ destructive/aggressive
- ○ withdrawn
- ○ inappropriate behavior
- ○ self-abusive behavior

VIII. EDUCATIONAL HISTORY

Current School (or preschool program): _____

Previous School(s): _____

Grade: _____ Teacher: _____

Is he/she enrolled in special education? _____

Please list any additional information that may be beneficial in completing assessment of this child:

_____

_____

_____

_____

_____

Signature/Relation to child