HUNTER COLLEGE
CENTER FOR COMMUNICATION DISORDERS

PRE-INTAKE HISTORY FORM
SPEECH-LANGUAGE-HEARING EVALUATION

Child's name _____ Sex:_____ Birthdate: _____ Age: _____

Address: _____

Phone:_____ Parent Business phone (or Cell)_____

Referred by: _____

Place of birth:_____ School: _____

Grade:_____ Teacher's Name _____

Other School's attended (and dates of attendance):_____

Name of person completing form: _____ Relationship _____

Pediatrician's name:_____ Address: _____

Father's full name: _____ Occupation: _____

Mother's full name: _____ Occupation: _____

Names and ages of brother's and/or sister's: _____

_____

Other persons living in the home (relationship to child): _____

_____

Language(s) spoken at home:_____

Statement of the problem (In your own words, what difficulty is your child having with speech, language, or hearing?) _____

_____

_____

When was it first noticed? _____

Does the problem vary, being better or worse at certain times? _____

_____

_____

_____

-continued-

Does the child have difficulty at school? If so, please describe. _____

_____

_____

Has the child received any special services at school or other clinics and/or hospitals (speech therapy, reading assistance, special class, visual, hearing, psychological evaluations, medical, etc.)?

TYPE OF SERVICE	**SCHOOL OR SPECIALIST**	**DATES**
_____	_____	_____
_____	_____	_____
_____	_____	_____

What questions would you like to have answered by this evaluation? _____

_____

_____

PRE-NATAL AND BIRTH HISTORY:

If child was adopted please indicate age at adoption and country of adoption.

_____

During this pregnancy did the mother have (please answer yes or no):

German Measles_____ Prenatal care_____

Bleeding _____ Use of alcohol _____

Falls/Accidents_____ Use of tobacco _____

RH incompatibility_____ Use of medications (please explain)

_____

_____

Is there a history of miscarriage or stillbirths?_____

Length of pregnancy _____ months Duration of labor _____ hours

Type of Delivery: normal _____ breech_____ Cesarean_____

Method of delivery: natural _____ induced _____ forceps_____

Birth weight: _____ lbs. _____ oz._____ Hospital of Birth_____

Did the baby have any of the following (please answer Yes or No):

Jaundice _____ feeding difficulty_____ breathing difficulty_____ surgery_____

MEDICAL HISTORY:

Please indicate the age at which your child has had any of the following:

Measles_____ Chicken Pox _____ Asthma _____

Meningitis _____ Seizures _____ Allergies _____

Tonsillitis _____ Earaches _____ Scarlet Fever _____

Please Name Any Other Illnesses and Age of Onset_____

_____

_____

DEVELOPMENTAL HISTORY:

Please indicate the age for the following:

First tooth_____ sat alone _____ crawled _____

Walked alone _____ toilet trained _____

First babbled_____ first words (age and words) _____

First phrases or sentences (age and words) _____

	Yes/No
Did child have difficulty learning to ride a bicycle?	_____
Does child fall or lose balance easily?	_____
Does child have difficulty grasping objects?	_____
Does child have difficulty sipping through a straw?	_____
Does child have any difficulty chewing or swallowing?	_____
Does child have any difficulty imitating arm movements?	_____
Does child have any difficulty imitating movements of facial expression?	_____
Does child play with other children?	_____
Does child have an interest in television?	_____
Does child feed him/her self?	_____
Does child dress him/her self?	_____
Does child sleep throughout the night?	_____
Does child seem to understand when spoken to?	_____
Does child have difficulty talking about his/her ideas using words?	_____
Is child able to concentrate on one activity?	_____
Is child able to separate from parent/caregiver?	_____

Does your child show preference for ☐left hand ☐right hand ☐neither hand