

SPEECH AND HEARING CLINIC
CALIFORNIA STATE UNIVERESITY, LONG BEACH
1250 BELLFLOWER BLVD.
LONG BEACH, CA 90840
(562) 985-4583

CHILD
INFORMATION QUESTIONNAIRE

(All information given on this questionnaire will be considered confidential.)

Birth Date _____

Name of Applicant _____ Age _____ Sex _____ Birth Place _____

Address _____ Phone _____

Father's Name _____ Age _____ Occupation _____

Address _____ Phone _____

Mother's Name _____ Age _____ Occupation _____

Address _____ Phone _____

List names, ages, and sex of other children _____

_____ Primar

y language spoken in home _____ Secondary language _____

Name of person filling out questionnaire _____ Relationship to Applicant _____

Address _____ Phone _____

Person (or agency) referring you to this clinic _____ Official position _____

If you have been examined in this clinic before, give approximate date of last appointment _____

SPEECH HISTORY

Please describe the child's communication problem now _____

What do you think is the cause of the child's speech problem? _____

_____ When

did child first notice it? _____

What was it like at onset? _____

How was it called to parent's attention? _____

What circumstances make it worse? _____

What circumstances make it better? _____

What were child's first words? _____ At what age were they said? _____

Did child babble before this? _____ At what age were words put together? _____

What were these words? _____

What methods were used to encourage early speech? _____

Hesitated or repeated words or sounds _____ Slow in learning new words _____ Hoarseness _____

Stopped talking for a period time _____ Discuss any that apply _____

Has child ever had a speech examination before? _____ When? _____

Name of examiner or clinic where child had his speech examined _____

Address _____

Has child had speech therapy before? _____ Name of therapist _____

Address _____

Has anything been done to overcome speech problem at home? _____

List any Speech/Hearing problems that members of family may have _____

DEVELOPMENTAL HISTORY

PREGNANCY:

At what month did child's mother first consult her physician? _____ Was everything normal? _____

If not, explain _____ Did she have regular examinations after that? _____

Did any abnormalities develop? _____ When? _____ What? _____

Did she vomit? ____ How many months did she vomit? ____ Did she gain weight? ____ How much? ____

Lose weight? ____ How much? ____ Did she have any disease or illness during this pregnancy? _____

What? _____ At what month? _____ Explain _____

Did she have any shocks or injuries during this pregnancy? _____ After? _____

At what month? _____ What was her health before this pregnancy? _____ After? _____

BIRTH OF CHILD

Total number of hours mother in labor _____ Hours of hard labor _____ Was delivery normal? _____

Instrumental? _____ In home? _____ In hospital _____ Was child full term? _____ Premature? _____

What month premature? ____ Did child do the following at birth: Cry _____ Breathe _____ Nurse _____

What measures were taken to make the child to do above? _____

Was child blue? _____ Jaundiced? _____ Bleeding? _____ Bruised? _____

Were any abnormalities noticed at birth? _____ Give details _____

How was child's health the first two weeks of life? _____

Give child's weight at birth _____ 6 mo. _____ 1 yr. _____ 5 yrs. _____ Present _____

Was child ever underweight? _____ How much? _____ Overweight? _____ How much? _____

How old was child when he held his head up while lying on his stomach? _____ While held upright? _____

How old was child when he crawled? _____ Sat alone? _____ Walked? _____ Fed self? _____

Tied shoe? _____ Was child younger or older than his brothers and sisters when they did the above? _____

Was he breast fed? _____ How long? _____ When was he given a bottle? _____ At what age did he

stop the bottle? _____ Were nipple holes made extra large? _____ Was he kept on schedule? _____

Was he ever a feeding problem? _____ At what age? _____ What was the nature of the problem? _____

Was there every anything unusual in child's development? _____

Name of child's doctor or medical group _____ Phone _____

Address _____

Is child taking any medication now? _____ What for? _____

Is child receiving any kind of treatment? _____ If yes, please describe _____

Does child have any physical handicaps? _____ Describe _____

Were teeth ever straightened? _____ When? _____ List any other major dental treatment _____

What operations has child had? _____

When did child have eyes examined last? _____ Is vision good now? _____ Remarks: _____

Has child had a hearing test? _____ When? _____ Where? _____

Address _____

Was child ever hard of hearing? (explain circumstances) _____

If child has had psychological test, give name and address of examiner.

Examiner: _____ Address _____

Provide the approximate ages at which your child suffered the following illnesses and conditions:

Adenoidectomy _____	Allergies _____	Asthma _____
Chicken Pox _____	Colds _____	Convulsions _____
Croup _____	Dizziness _____	Draining Ear _____
Ear Infections _____	Encephalitis _____	German Measles _____
Headaches _____	Hearing loss _____	High Fever _____
Influenza _____	Mastoiditis _____	Measles _____
Meningitis _____	Mumps _____	Noise Exposure _____
Otosclerosis _____	Pneumonia _____	Seizures _____
Sinusitis _____	Tinnitus _____	Tonsillectomy _____
Tonsillitis _____	Other _____	

SCHOOL HISTORY

Name of school child is now attending _____

Address of school _____

Give full name of child's home room teacher _____

What hours does child attend school now? _____

What grade is child in now? ___ Did child go to kindergarten? ___ Give age child entered first grade _____

List grades repeated _____ Skipped _____ Did student graduate from high school? _____

How far did child go in school? _____ If child stopped school, why? _____

Does child read aloud easily? _____ does child enjoy reading? _____

Has school seemed to help or aggravate the speech defect _____ Discuss _____

List student's subjects and grades for last semester _____

