

**CALIFORNIA STATE UNIVERSITY, LONG BEACH**



**SPEECH AND LANGUAGE CLINIC**  
1250 BELLFLOWER BLVD.  
LONG BEACH, CA 90840  
(562) 985-4583

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**CHILD INFORMATION QUESTIONNAIRE**

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

Name of Applicant \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Birth Place \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Father's Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

List names, ages, and sex of other children \_\_\_\_\_

Primary 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 your last appointment \_\_\_\_\_

**SPEECH HISTORY**

Please describe the communication problem the child is experiencing now.

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

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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? \_\_\_\_\_

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

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### 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 was 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/she held his head up while lying on his stomach? \_\_\_\_\_ While held upright? \_\_\_\_\_

How old was child when he/she crawled? \_\_\_\_\_ Sat alone? \_\_\_\_\_ Walked? \_\_\_\_\_ Fed self? \_\_\_\_\_

Tied shoe? \_\_\_\_\_ Was child younger or older than brothers and/or sisters when they did the above? \_\_\_\_\_

Was child breast fed? \_\_\_\_\_ How long? \_\_\_\_\_ When was child given a bottle? \_\_\_\_\_

At what age did child stop the bottle? \_\_\_\_\_ Were nipple holes made extra-large? \_\_\_\_\_

Was he/she kept on schedule? \_\_\_\_\_

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

### SCHOOL HISTORY

Name of school child is attending now \_\_\_\_\_

Address of school \_\_\_\_\_

Give full name of child's home room teacher \_\_\_\_\_

What days and hours does the child attend school \_\_\_\_\_

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 problem? \_\_\_\_\_ Discuss \_\_\_\_\_

List student's subjects and grades for last semester \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_