CALIFORNIA STATE UNIVERSITY, LONG BEACH

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

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.

_____

_____

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 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 _____

_____

_____