Hingham Speech & Language Therapy

169 Lincoln Street, Suite 202
Hingham, MA 02043
Phone: 617-840-5445 Fax: 781-875-3060
E-Mail: liz@hinghamspeechtherapy.com
Web: www.hinghamspeechtherapy.com

# Developmental History Form

**Client information:**

Name:____________________________ Date of Birth: ____________Age:__________
Form Completed by:________________________ Date:_________________________
Parents/Legal Guardian (check all that apply)
With whom does the child live? Both parents________ Mother____ Father______
Stepfather/Stepmother___ Other _______________ If so, who?______________

Are there any languages other than English spoken at home: No_________ yes ______
What languages?_______________ By whom____________________________________
How often? _________________________________

**Areas of Concern (Check all that apply):**
Behavioral/emotional____Listening____ Language____
Difficulty understanding language____ Health/medical____
Speech difficult to understand____Vision problems____
Social skills____Stuttering____ Feeding____

Why are you requesting this evaluation?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Has a speech pathologist, or other diagnostic specialist evaluated your child?
Please list resource/s and any diagnostic impressions determined:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Current school/pre-school/day care your child attends: _____________________________
Grade level:_________________________
If preschool/day care, list the days and times your child attends:______________________

List any special services that your child has received or is currently receiving (Early Intervention, Speech, Occupational, or other forms of therapy). Please include frequency and dates of services (e.g., 1x30 minutes/week from July 2013-December2013):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Is your child on an IEP (Individual Education Program) or an IFSP (Individual Family Service Plan)?______________________

If so, when did these services begin?________________________________

What services are being provided as part of this plan:____________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Developmental History:**

**Motor Development: Please list appropriate ages.**

Sat alone____________ Crawled ______________Stood Alone________________

Walked independently______________ Fed self with a spoon__________________

**Speech and Language Development: Please list appropriate ages.**

Spoke first words_____

Used two word sentences_____

Spoke in complete sentences_____

Does your child communicate primarily using speech?_____

Does your child communicate primarily using gestures?_____

Is your child's speech difficult for others to understand?_____

Does your child have difficulty following directions?_____

Does your child have difficulty answering questions?_____

**Medical History:**

Were there any complications during pregnancy and/or birth? _________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

List any significant past or present health problems (serious injury, high temperature or fever, allergies, asthma, frequent ear infections etc.):
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

List any medications taken on a regular basis:_______________________________________________
_____________________________________________________________________________________

List medical treatments (e.g. PE tubes, inhalers, ear wax removal):_______________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Audiological information:**

Has your child's hearing been evaluated?_____

If yes, when?_______Name of audiologist:______________________________________________

What were the findings?_______________________________________________________________

What play activities does your child enjoy?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Does she/he play primarily alone? _______________
Do you have any concerns about your child's social skills?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Please provide any additional information you feel may be helpful.

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________