



## PREGNANCY & BIRTH HISTORY

**Did you experience any problems during pregnancy?**

YES  NO

Nature of Problems:

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Was your child premature?

YES  NO

Gestation: \_\_\_\_\_ (weeks)

**Were there any problems during labour or birth?**

YES  NO

Nature of Problems:

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**Did your baby require assistance with the delivery?**

YES  NO

Details:

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**Was treatment required after birth?**

YES  NO

Nature of treatment:

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Was your baby breast fed?

YES  NO

Until what age? \_\_\_\_\_

Was your baby bottle fed?

YES  NO

Until what age? \_\_\_\_\_

**Did your baby have any feeding problems?**

YES  NO

*(e.g. vomiting, reflux or difficulty with sucking)*

Nature of Problems:

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**Did your baby transition easily to solids?**

YES  NO

Details:

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**Does your child now tolerate a range of food types & textures?**

YES  NO

Details:

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**Does your child frequently gag on solids?**

YES  NO

Details:

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What age did your child cease using a teated bottle for fluids?

\_\_\_\_\_ Months

**Did your child use a dummy/pacifier?**

YES  NO

What age did your child cease (completely) using it?

If your child is currently using a dummy, how often is it used?

**Does your child dribble?**

**YES**  **NO**

Details:

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## DEVELOPMENT

At what age did your child first sit alone without support? \_\_\_\_\_

At what age did your child first crawl? \_\_\_\_\_

At what age did your child walk unaided? \_\_\_\_\_

At what age was your child toilet trained?

**Day**  **Night**

Does your child seem awkward, un-coordinated?:

**YES**  **NO**

Details:

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## MEDICAL HISTORY

**What illnesses and/or accidents has your child had?**

Type of Illness	Age	Treatment

**Has your child ever had a convulsion?**

**YES**  **NO**

Details:

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**Does your child have difficulties with attention and concentration?**

**YES**  **NO**

Details:

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**How often does your child have colds?**

**Often**  **Sometimes**  **Never**

Details:

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**Is your child presently on any medication?**

**YES**  **NO**

If yes, what type of medication and for what reason?

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**Does your child have any physical handicaps?**

YES  NO

Details:

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**Has your child had a hearing test?**

YES  NO

If yes, when and where?

What were the results?

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**Has your child had many ear infections?**

YES  NO

Details:

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**Has your child been seen by any other health professionals?**

Please detail who, when and the reason?

**Occupational Therapist**

YES  NO

Details:

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**Psychologist**

YES  NO

Details:

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**Paediatrician**

YES  NO

Details:

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**Physiotherapist**

YES  NO

Details:

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YES  NO

Details:

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Please attach any relevant reports prior to the assessment

## SPEECH and LANGUAGE

Describe in your own words your child's difficulties:

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**Has anyone else in the family ever had a speech / language / literacy / learning difficulty?**

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**Did your child babble regularly as a baby?**  YES  NO  
**At what age did your child say their first words?** \_\_\_\_\_  
What were they? \_\_\_\_\_

**Did your child keep adding words once they started to talk?**  YES  NO  
Details: \_\_\_\_\_

**At what age did your child make small sentences such as:  
"want drink" or "me go"** \_\_\_\_\_  
**Has there been a change in their speech in the last  
3 months?**  YES  NO  
Details: \_\_\_\_\_

**Are there any problems at school?**  YES  NO  
*e.g. reading, writing, spelling, socialising or communication?*  
Details: \_\_\_\_\_

**Has your child received speech pathology or tutoring services in  
the past?**  YES  NO  
Details: \_\_\_\_\_

**Does your child receive assistance or support at school?**  YES  NO  
Details: \_\_\_\_\_

**Is there any other language spoken at home  
(apart from English)?**  YES  NO  
If yes, what language? \_\_\_\_\_

**Does your child understand the language?**  YES  NO  
Details: \_\_\_\_\_

**Please outline any further concerns you may have:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Thank you  
Speech-Language Pathologist***