

## Speech, Language and Hearing History

Please fill out this form as completely as possible and bring to the evaluation. If there are any items you do not fully understand, put a check mark in the left margin and we can discuss them when you come in for your appointment.

Date \_\_\_\_\_

Person completing this form \_\_\_\_\_

Relationship to child \_\_\_\_\_

### I. IDENTIFICATION

Child's name \_\_\_\_\_ DOB \_\_\_\_\_

Gender \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Mother's name \_\_\_\_\_ E/mail \_\_\_\_\_

Mother's address \_\_\_\_\_

Mother's employment \_\_\_\_\_ Work phone \_\_\_\_\_

Father's name \_\_\_\_\_ E/mail \_\_\_\_\_

Father's address \_\_\_\_\_

Father's employment \_\_\_\_\_ Work phone \_\_\_\_\_

Referred by \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Child's Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_

Pediatrician's address \_\_\_\_\_

What is your preferred mode of contact? E/mail  Phone  Other  \_\_\_\_\_

## II. STATEMENT OF THE PROBLEM

Describe as completely as possible the speech, language and hearing problem

---

---

---

---

---

When was the problem first noticed? \_\_\_\_\_

How has the problem changed since you first noticed it? \_\_\_\_\_

---

What has been done about it? \_\_\_\_\_

When your child has this problem, what is your typical response? \_\_\_\_\_

\_\_\_\_\_ Has this helped? \_\_\_\_\_

What do you think caused this problem? \_\_\_\_\_

---

Are there any family members or relatives who have or had speech, language or hearing problems? \_\_\_\_\_

---

Does your child feel he/she has a problem speaking? \_\_\_\_\_

Do you feel your child is more sensitive than the average child his/her age? \_\_\_\_\_

---

### III. SPEECH, LANGUAGE AND HEARING HISTORY

How much did your child babble and coo during the first 6 months? \_\_\_\_\_

When did he/she speak his first words? \_\_\_\_\_

What were your child's first few words? \_\_\_\_\_

How many words did your child use at 1 ½ years? \_\_\_\_\_

When did he/she begin to use 2-word sentences? \_\_\_\_\_

Does he/she use speech: Frequently       Occasionally       Never

Does he/she use many gestures? (Please give an example) \_\_\_\_\_

\_\_\_\_\_

Which does the child prefer to use?

Complete sentences       Phrases       One or two words

Sounds       Gestures

Does he/she make sound incorrectly? \_\_\_\_\_ If so, which ones? \_\_\_\_\_

Does he/she hesitate, "get stuck," repeat, or stutter on sounds or words? \_\_\_\_\_

If so, please describe what happens: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Peter R. Ramig, Ph.D. & Associates**  
**Associated Stuttering Treatment Clinics**  
 2885 Aurora Avenue, Bldg. 24, Boulder, CO 80303  
 Boulder & Longmont: 303-247-1632      Greenwood Village: 303-773-9550  
 Ft. Collins: 970-495-1920

**DANGER SIGNS**

		Not observed	Sometimes observed	Frequently observed
A	<b><u>Multiple part-word repetitions</u></b> Repeating the first letter or syllable of a word, such as t-t-table or ta-ta-table	_____	_____	_____
B	<b><u>Prolongation</u></b> Stretching out a sound, such as r____abbit	_____	_____	_____
C	<b><u>“Schwa vowel”</u></b> Use of the weak (‘uh’) vowel. For example, instead of saying bay-bay-bay-baby, the child substitutes buh-buh-buh-baby	_____	_____	_____
D	<b><u>Struggle and tension</u></b> The child struggles and forces in his/her attempt to say a word	_____	_____	_____
E	<b><u>Pitch and loudness rise</u></b> As the child repeats and prolongs, the pitch and loudness of his voice increases	_____	_____	_____
F	<b><u>Tremors</u></b> Uncontrolled quivering of the lips or tongue may occur as the child repeats or prolongs sounds or syllables.	_____	_____	_____
G	<b><u>Avoidance</u></b> An unusual number of pauses, substitutions of words, interjection of extraneous sounds, words or phrases, avoidance of talking	_____	_____	_____
H	<b><u>Fear</u></b> As the child approaches a sound that gives him trouble, he may display an expression of fear.	_____	_____	_____
I	<b><u>Difficulty in starting and/or sustaining airflow or voicing speech</u></b> This is heard most often when the child begins sentences or phrases. Breathing may be irregular and speech may occur in spurts as the child struggles to keep his voice on	_____	_____	_____

**Peter R. Ramig, Ph.D. & Associates**  
**Associated Stuttering Treatment Clinics**  
2885 Aurora Avenue, Bldg. 24, Boulder, CO 80303  
Boulder & Longmont: 303-247-1632      Greenwood Village: 303-773-9550  
Ft. Collins: 970-495-1920

How does his/her voice sound? Normal \_\_\_\_\_ Too high \_\_\_\_\_ Too  
high \_\_\_\_\_ Too low \_\_\_\_\_ Hoarse \_\_\_\_\_ Nasal \_\_\_\_\_  
How well can he/she be understood? By his/her parents \_\_\_\_\_ by his/her  
brothers & sisters \_\_\_\_\_ and playmates \_\_\_\_\_ by relatives and strangers \_\_\_\_\_  
Did your child acquire speech and then slow down or stop talking? \_\_\_\_\_  
How well does he/she understand what is said to him/her? \_\_\_\_\_  
Does your child hear adequately? \_\_\_\_\_ Does his/her hearing  
appear to be constant or does it vary? \_\_\_\_\_ I his/her hearing poorer  
when he/she has a cold? \_\_\_\_\_

**IV. GENERAL DEVELOPMENT**

**A. Pregnancy and birth history**

Total number of pregnancies \_\_\_\_\_ Which pregnancy was the child \_\_\_\_\_  
Length of pregnancy? \_\_\_\_\_ Was it difficult \_\_\_\_\_  
What illnesses, diseases, and accidents occurred during pregnancy? \_\_\_\_\_  
Was there a blood incompatibility between the father and mother? \_\_\_\_\_  
Age of mother at child's birth \_\_\_\_\_ Age of father at child's birth \_\_\_\_\_  
What was the length of labor? \_\_\_\_\_ Were there any unusual problems at  
birth (breech birth, caesarean birth, others)? If so, describe \_\_\_\_\_  
At what age did infant regain birth weight? \_\_\_\_\_

**B. Developmental**

At what age did the following occur?

Developmental milestone	Age acquired
Held head erect while lying on stomach	
Rolled over alone	
Sat alone unsupported	
Crawled	
Stood alone	
Walked unaided	
Fed self with spoon	
Had first tooth	
Bladder trained	
Bowel trained	
Dressed and undressed self	
What hand does he/she prefer?	
Has handedness ever changed? If so, at what age?	

How would you describe your child's current physical development?

---



---



---

**V. GENERAL DEVELOPMENT**

Please check these as they apply to your child.

	Yes	No	<i>Explain: give ages if possible</i>
Cried less than normal amount			
Laughed less than normal amount			
Yelled and screech to attract attention or express annoyance			
Head banging and foot stamping			
Extremely sensitive to vibration			
Very alert to gesture, facial expression or movement			
Shuffled feet while walking			
Generally indifferent to sound			
Did not respond to noises (car horn, telephones) but not to speech			
Difficulty using tongue			
Difficulty swallowing			
Talk through nose			
Mouth Breather			
Tongue-tied			
Difficulty chewing			
Drooled a lot			
Food came out of nose			
Constant throat clearing			
Difficulty breathing			
Large tongue			
Difficult moving mouth			

**VI. MEDICAL HISTORY**

Is your child under the care of a doctor? \_\_\_\_\_ Why? \_\_\_\_\_

Is he/she taking medication? \_\_\_\_\_ Type \_\_\_\_\_

Why? \_\_\_\_\_

**Peter R. Ramig, Ph.D. & Associates**  
**Associated Stuttering Treatment Clinics**

2885 Aurora Avenue, Bldg. 24, Boulder, CO 80303  
 Boulder & Longmont: 303-247-1632      Greenwood Village: 303-773-9550  
 Ft. Collins: 970-495-1920

At what ages did any of the following illnesses, problems, or operations occur? Please indicate how serious they were.

	Age	Mild	Mod.	Severe		Age	Mild	Mod.	Severe
Adenoidectomy					Heart Problems				
Allergies					High fevers				
Asthma					Influenza				
Blood Disease					Mastoidectomy				
Cataracts					Measles				
Chicken Pox					Meningitis				
Chronic Colds					Mumps				
Convulsions					Muscle disorder				
Cross-eyed					Nerve disorder				
Croup					Orthodontia				
Dental Problems					Pneumonia				
Diphtheria					Polio				
Earaches					Rheumatic fever				
Ear Infections					Scarlet fever				
Encephalitis					Tonsillectomy				
Headaches					Tonsillitis				
Head Injuries					Whooping cough				

Has the child ever fallen or had a severe blow or the head? \_\_\_\_\_

If so, did he/she loose consciousness? \_\_\_\_\_ Did it cause a concussion? \_\_\_\_\_

Did it cause: Nausea \_\_\_\_\_ Vomiting \_\_\_\_\_ Drowsiness \_\_\_\_\_

Other \_\_\_\_\_

Describe any other serious illnesses, injuries, operations or physical problems not mentioned above \_\_\_\_\_

What illnesses have been accompanied by an extremely long, high fever? \_\_\_\_\_

**Peter R. Ramig, Ph.D. & Associates**  
**Associated Stuttering Treatment Clinics**  
 2885 Aurora Avenue, Bldg. 24, Boulder, CO 80303  
 Boulder & Longmont: 303-247-1632      Greenwood Village: 303-773-9550  
 Ft. Collins: 970-495-1920

Temperature: \_\_\_\_\_ How long did the fever last? \_\_\_\_\_

Which of the above required hospitalization? \_\_\_\_\_

**VII. BEHAVIOR**

	Yes	No	Explain: give ages if possible
Eating problems			
Sleeping problems			
Toilet training problems			
Difficulty concentrating			
Needed a lot of discipline			
Underactive e			
Excitable			
Laughs easily			
Cried a lot			
Difficult to manage			
Overactive			
Sensitive			
Personality Problem			
Gets along with children			
Gets along with adults			
Emotional			
Stays with an activity			
Makes friends easily			
Happy			
Irritable			
Prefers to play alone			

**VIII. EDUCATIONAL HISTORY**

Did child attend day care or nursery school? \_\_\_\_\_ Where? \_\_\_\_\_

Ages \_\_\_\_\_ Kindergarten \_\_\_\_\_ Where? \_\_\_\_\_

School now attending \_\_\_\_\_ City \_\_\_\_\_

**Peter R. Ramig, Ph.D. & Associates**  
**Associated Stuttering Treatment Clinics**  
2885 Aurora Avenue, Bldg. 24, Boulder, CO 80303  
Boulder & Longmont: 303-247-1632     Greenwood Village: 303-773-9550  
Ft. Collins: 970-495-1920

Grade he/she is now in \_\_\_\_\_ Grades skipped \_\_\_\_\_

What are his average grades? \_\_\_\_\_ Best subjects \_\_\_\_\_ Poorest \_\_\_\_\_

How do you discipline your child? \_\_\_\_\_

What are the child's favorite play activities? \_\_\_\_\_

Is the child frequently absent from school? \_\_\_\_\_ If so, why? \_\_\_\_\_

How does the child feel about school and his teacher(s)? \_\_\_\_\_

What is your impression of your child's learning abilities? \_\_\_\_\_

Describe any speech, language, hearing, psychological and special education services that have been performed, including where these were obtained. How often was your child seen in this service? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IX. HOME AND FAMILY INFORMATION**

Last grade father completed in school \_\_\_\_\_ Degree(s) \_\_\_\_\_

Last grade mother completed in school \_\_\_\_\_ Degree(s) \_\_\_\_\_

Are parents divorced? \_\_\_\_\_ Separated? \_\_\_\_\_ Live together? \_\_\_\_\_

**Peter R. Ramig, Ph.D. & Associates**  
**Associated Stuttering Treatment Clinics**  
 2885 Aurora Avenue, Bldg. 24, Boulder, CO 80303  
 Boulder & Longmont: 303-247-1632      Greenwood Village: 303-773-9550  
 Ft. Collins: 970-495-1920

Brothers and sisters:

Name	Age	Gender	Grade in school	Speech, hearing or medical problems (if any)
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Are there any other languages spoken in the home? \_\_\_\_\_ If so, what? \_\_\_\_\_

By whom and how often? \_\_\_\_\_

Please add any additional information you feel will help us I understanding your child and his/her problem(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How do you feel about your child's problem? \_\_\_\_\_

\_\_\_\_\_

How would you like us to help? \_\_\_\_\_

\_\_\_\_\_