MT. VERNON
COMMUNITY SCHOOL CORPORATION

Speech and Language Department
PARENT INPUT / HEALTH & DEVELOPMENTAL HISTORY
(To be completed by parent or guardian)

Person Completing Form:_____ **Relationship to Student:**_____

FAMILY INFORMATION:

Student's Name:_____ Male ____ Female ___
Date of Birth:_____ Current Grade:_____
Current School:_____ Mother's Name: _____
Address:_____ Mother's Phone #: _____
_____ Father's Name: _____
Father's Phone #:_____

▸Child lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ Other: _____

▸Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Other: _____

▸List other adults and children living within the home and their relationship to the child:

Name	*Age*	*Relationship*

▸ Please list the primary language spoken in the home and indicate any cultural concerns that may affect your child's learning:_____
_____.

HEALTH & MEDICAL HISTORY

▸ Were there any complications with pregnancy or delivery? ☐Yes ☐No
If yes, please explain:_____
_____.

A. Duration of pregnancy _____.
B. Delivery of baby:
____Normal ____Forceps used _____ Induced
____Breech ____Caesarean _____Other: _____

▸ Please estimate as closely as you can the age (months or years) at which the child:
Walked independently_____ Used single words_____
Used 3+ word phrases_____ Was potty trained_____

▸ Has the child ever had any vision, hearing, or speech problems?
_____
If yes, please explain:
_____

_____

—

Overall, how is the child's: Hearing: ☐Good ☐ Fair ☐Poor ☐Unknown
Vision: ☐Good ☐ Fair ☐Poor ☐Unknown
Speech: ☐Good ☐ Fair ☐Poor ☐Unknown

Comments: _____
_____

- Does your child have a history of any of the following?

☐ Ear Infections ☐ Allergies ☐ Impacted Wax ☐ Tubes in Ears (Date of insertion: _____)

- Has the child had any chronic health problems? (e.g. asthma, diabetes, heart conditions), if yes, please explain:_____
_____

- Has the child had any accidents, operations, or prolonged illnesses? (i.e., otitis media, pneumonia, seizures, head injury, severe bruises, broken bones, tonsils removed, tubes in ears, etc.) ☐Yes ☐No

If yes, please explain:_____
_____

- Does the child have any allergies? ☐Yes ☐No

If yes, please explain:_____

- Does the child take any kind of medication regularly? ☐Yes ☐No

If yes, please explain type, dosage, reason prescribed, and side effects experienced:_____
_____
—

- Family Physician: _____

Is he/she aware of your child's difficulties? ☐Yes ☐No

- Do you have any concerns regarding the child's fine or gross motor skills? ☐Yes ☐No

If yes, please explain:_____
_____

- Does anyone in the family have a history of the following:

____Visual Problems ____Hearing Problems
____Cognitive Disability ____Attention Deficit Disorder
____Dyslexia ____Seizures or Convulsion
____Speech/Language Difficulty ____Heart Defects/Difficulty
____Mental Illness ____Autism Spectrum Disorder
____Developmental Delay ____Other_____

Comments:_____
_____

▸ Please describe any significant sensory issues that your child has experiences (i.e. over- or under-sensitivity to sounds, touch/textures, light/visual stimuli and/or tastes/smells):

_____

_____

_

_____

_

COMMUNICATION HISTORY:

▸ At what age did you first notice the communication concern for your child (i.e. for articulation, voice, fluency social skills and/or language skills)? _____

_____

Please describe what you observed:

_____

_____

.

▸ For articulation, how much of your child's speech is intelligible to (i.e. understood by):
Familiar Listener: _____ Unfamiliar Listener: _____

▸ Does your child have difficulty with oral motor skills (i.e. sucking/chewing/eating skills, difficulty using tongue lips, drooling, etc.)? ☐Yes ☐No
If yes, please describe: _____
_____.

▸ For fluency/stuttering, in what speaking contexts do you notice your child's dysfluencies?

_____

_____

How often would you say they occur: _____

▸ For language, please check the following areas that may be of a concern to you:

_____ Difficulty following directions
_____ Difficulty learning new concepts/vocabulary
_____ Difficulty interacting with peers
_____ Difficulty initiating and/or maintaining conversation
_____ Difficulty using grammar when speaking or in writing
_____ Difficulty asking and/or answering questions
_____ Difficulty learning to read
_____ Difficulty learning rhymes
_____ Other: _____

▸ Please list any concerns regarding the child's social skills: _____
_____.

▸ If English is NOT the primary/native language spoken in the home, are there any concerns about your child's understanding and use of his/her primary native speech-language skills? ☐Yes ☐No
If yes, please describe: _____

_____

SCHOOL/ACADEMIC INFORMATION:

Please list previous schools your child has attended:

School	Location	Grades	Dates
_____	_____	_____	_____
_	_	_	_

_____ _____ _____ _____
_ _ _ _
_____ _____ _____ _____
_ _ _ _

- Did your child receive special education services at any previously attended school? ☐Yes ☐No
  If yes, please describe: _____

- Did your child attend preschool? ☐Yes ☐No If yes, where? _____

- Did he/she receive any special education services while attending preschool? ☐Yes ☐No
  If yes, please describe:

_____

- Did he/she receive any services through First Steps (birth – three) or other therapy services? ☐Yes ☐No
  If yes, please describe:

_____

- Please indicate the type(s) of difficulties your child is having, or what you are concerned about?_____
_____.

OTHER PERTINENT INFORMATION:

- Please check the positive characteristics that describe the child:

_____ Good sense of humor	_____ Chooses similar aged friends
_____ Appears happy	_____ Has many interests
_____ Friendly	_____ Tries hard
_____ Liked by other children	_____ Likes School
_____ Good sport	_____ Courteous

Additional areas of strength:_____

_____

- Please list your child's interests/hobbies:

_____
_____
__

- Please check all areas of concern regarding the child:

_____ Lacks motivation	_____ Low self-concept
_____ Easily frustrated	_____ Bed wetting
_____ Cannot sit still	_____ Nail biting
_____ Overly talkative	_____ Depressed or Anxious
_____ Short attention span	_____ Unusual fears
_____ Daydreams frequently	_____ Does not sleep well
_____ Temper tantrums	_____ Has few close friends
_____ Aggressiveness	_____ Frequent physical complaints
_____ Shyness	_____ Uncooperative
_____ Following directions	_____ Unorganized or frequently lose things
_____ Cannot get started or stay on task	

Additional areas of concern:_____

_____.

▸ Have any of the following home circumstances occurred within past 12 months that may be influencing the child's behavior?

_____Parents separated
_____Parents divorced
_____Family accident
_____Family illness
_____Other (please specify)_____

_____Death in family
_____Birth in family
_____Changed schools
_____Family moved

Choose one of the following:

☐ I give permission for this information to be used in a multidisciplinary team report.

☐ I do ***NOT*** give permission for this information to be used in a multidisciplinary team report.

_____ _____

Signature **Date**