HearSay Services of Delaware
104 N.E. Front Street
Milford, Delaware 19963

CHILD HISTORY FORM

Child's Name_____ Today's Date_____

M___ F___ Date of Birth _____

Address (City, State, Zip Code)_____

Phone Number(s)_____

Parent(s) name(s)_____

Name of person completing this form _____

Relationship to patient _____

School_____Grade_____Teacher_____

Person/Physician who sent you_____

Reason for coming _____

Pregnancy and Birth History

Delivery: Vaginal birth _____C-section_____ Birth weight_____

	Yes	**No**
Length of pregnancy (weeks/months) _____		
Did the pregnancy have any problems?	____	____
Did the delivery have any problems?	____	____
Was the delivery premature?	____	____
Did mother have any illnesses during pregnancy?	____	____
Did mother take any medications during pregnancy?	____	____
After birth did the child have:		
Anoxia (not getting enough oxygen)?	____	____
Need an incubator?	____	____
Any head, neck, ear problems?	____	____
Surgery?	____	____
Infections needing medication?	____	____
Treatment for jaundice (yellow skin and eyes)?	____	____
Spend extra time in the hospital?	____	____

If yes to any of the above, please explain _____

_____

Hearing History

	Yes	**No**
Do you have any concerns with your child's hearing?	____	____
Does your frequently **not** respond to your voice?	____	____
Does your child **not** respond to loud noises?	____	____
Has your child's hearing ever been tested?	____	____

If so, by whom, when, and results_____

	Yes	**No**
Does your child wear hearing aids?	____	____

Type of hearing instruments: ITE____ BTE ____ 1 ear ____ Both Ears ___. How many years have they been worn?___ Are they satisfactory? Yes____No____

Do any family members have hearing loss (immediate or extended family) that began before age 30? Yes____ No ____

Please list all prescription or over-the-counter medications your child is taking and why s/he takes them_____

_____

Medical History **Yes No**

Do you have any medical concerns about your child? ____ ____

If yes, please explain_____

_____

Please check if your child has had any of the following:

Ear infections___Chicken pox____Vision problems ____Allergies ____
Meningitis (brain and spinal cord infection)____Kidney problems ____Seizures ____
Ear Surgery____Measles____Head trauma ____Other____

Please explain any that you checked_____

_____

Other medical concerns_____

Physical Development History

Do you have any concerns with your child's physical development? Yes ____ No____ If yes, please explain _____

Does your child lose his/her balance or fall easily? ____ Yes ____ No

Speech and Language History

Do you have any concerns with your child's speech and language? Yes ____ No____

If yes, please explain_____

_____

Is your child currently receiving speech and/or language therapy? Yes____ No____

Educational History

Is your child working at grade level? Yes____No____

If not, please explain_____

_____

Please explain any concerns presented by the classroom teacher_____

_____

Does your child: Have trouble paying attention or concentrating? Yes____No____

Receive any special services? Yes____No____

If yes to any of the above, briefly explain_____

_____

Thank you for choosing HearSay Services!