



ADAMS WELLS

SPECIAL SERVICES COOPERATIVE

Speech-Language Social Developmental History

Identifying and Family Information

Child's Name: Birthdate: Sex: M F

Caregiver 1 Name(s): Relationship:
Address: Phone:
Email:

Student Lives Here: Yes No Legal Guardian: Yes No

Caregiver 2 Name(s): Relationship:
Address: Phone:
Email:

Student Lives Here: Yes No Legal Guardian: Yes No

Caregiver 3 Name(s): Relationship:
Address: Phone:
Email:

Student Lives Here: Yes No Legal Guardian: Yes No

Please list children and adults who live in the child's primary home.

| Name | Age | Relationship |
|------|-----|--------------|
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Previous Interventions and Services - Check all that apply



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First Steps

HeadStart

Preschool

ABA

O.T.

Speech/Language Services

Speech, Language, and Learning Information - Check all that apply

Does your child...

- choke on food or liquids?
- repeat sounds, words, or phrases over and over?
- understand what you are saying?
- retrieve/point to common objects upon request (ball, cup, shoe)?
- follow simple directions ("Shut the door" or "Get your shoes")
- respond correctly to yes/no questions?
- respond correctly to who/what/where/when/why questions?

Describe your child's language abilities...

- no communication
- gestures/body language
- sign language
- sounds (vowels, grunting)
- PECS
- single words (shoe, dog, up)
- vocal - 2 to 4 word phrases
- vocal - sentences

- 1) If your child uses few words/signs, what are they?
- 2) If your child uses a device system to communicate, what are they using?
- 3) Please describe your child's strengths.
- 4) Please describe your concern about your child's speech, language, or learning abilities.
- 5) Are there situations in which your child has particular difficulties? Yes No

If yes, please describe.



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Is your child bilingual? Yes No Other Language:

What is the primary language used at home?

How has your child's speech, language, or learning difficulties affected the following?

- a) Social interaction with peers:
- b) Willingness to talk to others:
- c) Participation in the classroom:
- d) Academic success:

Is there anything else you feel we should know about your child?

Medical and Developmental History

- 1) Does your child have any health concerns or medical diagnoses?
- 2) Please list any medications that your child takes regularly.
- 3) Has your child had any ear infections? Yes No If yes, how many?
- 4) Has your child had tubes placed to drain fluid? Yes No
- 5) Has your child's hearing been tested? Yes No

If yes, please provide the date and results of the testing.

Social History

- 1) What opportunities does your child have to play with children of his/her age?
- 2) What activities does your child enjoy?
- 3) Does your child primarily play:



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alone

with other children

either alone or with others

Behavior Characteristics - Check all that apply

cooperative

restless

attentive

poor eye contact

easily distracted

stubborn

aggressive

destroys items

withdrawn

easily frustrated

willing to try new activities

Form completed by:

Date: