Nevada Speech and Therapy Group

Quality In-home Speech Therapy

COMMUNICATION HISTORY

Child Name: _____

Describe your concerns regarding your child's communication skills: _____

_____

When did you first become concerned? _____

How has the condition/problem changed since your initial concern? _____

_____

What has been done about this concern? _____

Is child non-verbal?	Yes	No
Does child use sign language, pictures, gestures and/or communication device?	Yes	No
Which? _____		
Is your child difficult to understand?	Yes	No
Does child display behaviors of over activity?	Yes	No
Does child become distracted easily?	Yes	No
Does child get stuck on, hesitate or repeat sound (stutter)?	Yes	No
Does child speak in complete sentences?	Yes	No
Did child acquire speech and then appear to slow down or stop talking?	Yes	No
Does child's communication appear delayed when compared to peer?	Yes	No
Does child speak or understand another language besides English?	Yes	No
Does child have a hoarse sounding voice?	Yes	No
Does child yell more than normal?	Yes	No
Does child echo/repeat language he/she hears, but does not use it functionally?	Yes	No
Does child have a difficult time following directions?	Yes	No
Does child have difficult time explaining information (e.g., how he/she got hurt)?	Yes	No
Does child use repetitive actions (e.g., lining up objects, spinning toys, flapping hands)?	Yes	No
Does child dislike/shy away from interactions with family/unfamiliar people?	Yes	No
Does child have a difficult time paying attention to gestures/facial expressions?	Yes	No
Does child have poor eye contact?	Yes	No
Does child have a difficult time controlling his/her behaviors?	Yes	No
Does child play with toys appropriately?	Yes	No
Does child have a family history of seizure disorder?	Yes	No
Does child use a "staring off" behavior?	Yes	No
Does child have a difficult time sleeping (e.g., nightmares, waking up crying)?	Yes	No