Beebe Health Care Rehabilitation Services
Evaluation- Speech/ Language Pathology
Speech Language History Form - Pediatric

Patient Identification Label

SPEECH LANGUAGE HISTORY

Do you have difficulty?

SYMPTOMS	YES	NO
Swallowing		
Expressing language/communicating wants or needs		
Saying certain sounds		
Understanding language		
With Orientation or Memory		
Solving Problems		
Focusing or maintaining attention		
Reading/ Writing		
Finding or thinking of words		
Maintaining eye contact, taking turns in conversation		
With Stuttering		
Following directions		
Coordinating tongue, cheek, lip movement (oral motor weakness)		
With your voice		

Are there any other difficulties besides what is listed above? ____
____
____
____
____

Have you had speech therapy before? Where? ____
When? ____
How long? ____

What is your child's awareness of this problem? ____
____
____

When did you first notice this problem? ____
____
____

Parent/Guardian Signature: ______________________________ **Date:** __________ **Time:** __________

Therapist Signature: ______________________________ **Date:** __________ **Time:** __________