MICHELE VOGEL SNAPPER MS CCC SLP

Brief Developmental History

Name of Child: _____ **Parent Name: _____**

DOB: _____ Room # _____ **Address: _____**

City: _____ State:_____ Zip:_____

Phone # Cell _____ **Home # _____** **Email: _____**

Parent Concerns: _____

Medical History:

Please describe the overall health of your child? _____

Does your child have (please circle Yes or No):

Ear Infections Yes No If yes, how often? _____

Allergies Yes No **Asthma** Yes No **Hearing Loss** Yes No **Glasses** Yes No

Reflux Yes No **GI Concerns** Yes No **Sleeping Issues** Yes No **Sensory Integration** Yes No

Are there any pertinent medical concerns or diagnosis I should be aware of? Yes No

If yes, explain: _____

Is your child currently taking any medications? Yes No

If yes, what medications?_____

Has your child previously been evaluated or received treatment by another SLP, OT, PT. Birth-Three or any other developmental specialist? Yes No

Is your child currently receiving speech therapy? Yes No

Do you have any concerns about your child's ability to eat? Yes No

Did your child have any difficultly nursing or drinking from a bottle? Yes No

Developmental Milestones:

At what age did your child:

Sit up _____ **Stand Unassisted _____** **Crawl _____** **First Word _____**