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Patient History – Child

Name: ______________________________

Date of Birth: ______________ Age: ______ Sex: ☐ Male ☐ Female

Address: ______________________________

City: ______________ State ______ Zip: ______________

Telephone: ______________________________

Person Completing This Form: ______________________________

Relationship to Client: ______________________________

Mother's Name: ______________________ Age: ______

Mother's Occupation: ______________________________

Father's Name: ______________________ Age: ______

Father's Occupation: ______________________________

List all children in the family from oldest to youngest

Name	Age	Sex	Grade in School	General Health

Does anyone else in the family have speech, language, or hearing problems?

☐ Yes ☐ No

If yes, please describe: ____________________

Who referred you for the evaluation? ____________________

What is your child's current diagnosis? ____________________

Child's pediatrician or family doctor ____________________

Address ____________________

Other doctor(s) treating the child ____________________

Has the child had any previous testing or therapy for speech, language, or hearing problems?

☐ Yes ☐ No

If yes, name of agency and date tested ____________________

(Please request that copies of all test results be sent to our office)

Other therapies past or present?

What is your primary concern with your child's speech, language, and communication?

What are your expectations for therapy and goals you wish to work towards with your child?

BIRTH HISTORY

Weight of child at birth ________________ Was the child full term? ☐ Yes ☐ No

Were there any unusual factors relating to the pregnancy (such as toxemia, X-ray treatments, RH negative, German measles, other illnesses, drugs or medications, previous miscarriages)?

☐ Yes ☐ No

If yes, please describe:

____

____

Type of birth:

☐ Normal ☐ Induced ☐ Forceps ☐ Caesarean ☐ Premature; How many weeks _____?

Were there any physical deformities or malformations observed at birth (such as "blueness," jaundice, abnormal shape of head)? ☐ Yes ☐ No

If yes, please describe: ____

DEVELOPMENTAL HISTORY

Give ages of development for the following behaviors:

Sitting unsupported_____ Walking _____

Eating solid foods _____ Self-feeding _____

Crawling _____ Self-dressing _____

Standing alone _____ Bladder/bowel control _____

Do you feel that the child was late or had difficulty in the development of these behaviors?

☐ Yes ☐ No

Is your child right or left handed?_______ Able to use: open cup ☐ spoon ☐ straw ☐

Any difficulty? (Y/N) Swallowing:___ Drinking:_____ Chewing:_____ Blowing:___ Drooling:___ Food allergies:_____

Favorite Foods:_______________ Aversive Foods (if any) ______________________

Attention span: for self-directed activities:_________ Adult directed:___________

Eating and sleeping patterns:____________________

MEDICAL HISTORY

Date and type of last medical examination____

Medications:____

Does your child have a current diagnosis?

Please check if your child has had any of the following (and if so, at what age):

☐ Feet First ☐ Mumps ☐ Croup Encephalitis ☐ Chronic colds ☐ Heart trouble
☐ Seizures ☐ Chicken pox ☐ Pneumonia ☐ Rheumatic fever
☐ High fevers ☐ Whooping cough ☐ Tonsillitis ☐ Tuberculosis ☐ Thyroid
☐ Measles ☐ Diphtheria ☐ Meningitis ☐ Sinusitis ☐ Asthma
☐ Enlarged glands

If you checked any of the above, please explain____

Is your child subject to frequent colds, sore throats? ☐ Yes ☐ No

Has the child had allergies, hay fever, etc.? ☐ Yes ☐ No

If yes, please describe: ____

Does the child tend to breathe with mouth open? ☐ Yes ☐ No

Has the child had any operations? ☐ Yes ☐ No

If yes, please describe: ____

Has the child had tonsils and adenoids removed? ☐ Yes ☐ No

If yes, when? ____

Has the child had any ear trouble (such as earaches, infection, running ears, evidence of hearing loss)? ☐ Yes ☐ No

If yes, please describe: ____

Has hearing been tested? ☐ Yes ☐ No If yes, when? ____________________

Results: ____

Has the child ever had ear (PE) tubes inserted? ☐ Yes ☐ No

If yes, when? ____

If yes, does the child still have ear (PE) tubes? ☐ Yes ☐ No

Has the child ever worn eyeglasses or had any difficulty with eyes? ☐ Yes ☐ No

If yes, please describe: ____

Does the child have any dental problems? ☐ Yes ☐ No

If yes, please describe: ______________________________

Has the child seen a specialist for any reason? ☐ Yes ☐ No If yes, please explain:

____

____

EDUCATION HISTORY

Current School ______________________________

Address ______________________________

City ______________________________ State __________ Zip __________

Grade __________ Teacher ______________________________

Does your child have an Individualized Education Plan (IEP)? If Yes, must provide a copy before therapy. ☐ **Yes** ☐ **No**

Does the child like school? ☐ Yes ☐ No

Does the child like the teacher? ☐ Yes ☐ No

Describe performance in school (please note strong and weak areas)

____

____

____

Does the child attend any special classes (such as speech therapy, language development, reading, resource room, special education classroom)? ☐ Yes ☐ No

If yes, please describe:

____

____

DAILY BEHAVIOR

Where does the child usually play? ______________________

Are there children close to the child's age in the neighborhood? ☐ Yes ☐ No

Does the child prefer to play alone? ☐ Yes ☐ No

Does the child prefer to play with older or younger children? ______________________

Does the child have a close friend? ☐ Yes ☐ No

What are your most frequent discipline problems with this child?

____

____

Who does the disciplining? ______________________

How do you discipline?

____

____

What does the child do well?

____

____

What does the child have trouble doing?

____

____

Does the child have difficulty concentrating? ______________________

COMMUNICATION HISTORY

Is the child's speech understandable to you? ☐ to friends? ☐ to strangers? ☐
to other family members? ☐
Is English the primary language spoken at home? ☐ Yes ☐ No If No, please list other languages spoken.

List sounds or words that the child has trouble saying

How does the child compare with siblings/relatives in speech development?

Does the child use words in meaningful ways for his/her age? ☐ Yes ☐ No

Give examples of sentences the child uses by himself/herself (not sentences that are repeated after you):

At what age did the child babble? ____________ say first words? ____________

put two words together in a sentence? ____________ use three-word sentences? ____________

Does the child seem to understand directions? ☐ Yes ☐ No

Does the child prefer to use speech or gestures when communicating?

Do you have any further questions?

Patient or Parent/Guardian Signature

Relationship to Patient

Date