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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