
Patient History

Date _____

BACKGROUND INFORMATION

Child's name _____ Birth Date _____ Age _____

Referred by _____

Father's Name _____ Mother's Name _____

Father's Address _____ Mother's Address _____

City _____ Zip _____ City _____ Zip _____

Phone (h) _____ Phone (h) _____

Phone (c) _____ Phone (c) _____

Email _____ Email _____

Father's Occupation _____ Mother's Occupation _____

Marital Status of Parents _____ Language spoken in home _____

*Is email a good way to correspond for you?

Persons other than parents living in the home:

Name	Relationship	Age	School	Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Child's School _____ Grade _____ Teacher _____

What feedback have you received from the school regarding your child's participation?

REFERRAL CONCERNS

Do you believe your child needs speech therapy? _____

Describe as clearly as possible your child's difficulty with behavior, speech, hearing, language, voice, etc. Give any information you believe may be relevant to the problem: what it is, what the causes may be, and when you first noticed the problem. What steps have you taken to help? _____

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What do you hope to achieve from this evaluation? _____

What would you most like your child to learn? _____

PRIOR EVALUATIONS

Pediatrician _____ Phone _____

Address _____ City _____ Zip _____

Medical Specialist (Neurologist, etc.) _____

Psychologist _____

Speech/Language Pathologist _____

Physical or Occupational Therapist _____

Other _____

MEDICAL HISTORY

Were there any problems during pregnancy or difficulties at birth? _____

Was your child premature _____

Has your child been hospitalized at any time? _____

History of seizures? _____ Accidents? _____

Other medical conditions _____ Allergies? _____

Has your child's vision been evaluated? _____ Results _____

Are there any diagnosed mental, physical or emotional disabilities? _____

Does anyone in your family have a history of learning disabilities? _____ Describe _____

HEARING

Does your child have frequent colds? _____ Ear infections? _____ Tubes in ear? _____

Does your child have a suspected or known hearing loss? _____

Has your child had a hearing test before? _____ When? _____

Where? _____ Results _____

Patient History

DEVELOPMENTAL HISTORY

Explain any difficulties in:

Overall development (rapid, slow, average) _____

Coordination and balance (good, fair, clumsy, awkward, etc.) _____

Self-help skills (dressing, washing, brushing teeth, etc.) _____

Oral habits (thumb sucking, drooling, mouth-breathing) _____

Eating and drinking (eating non-food items, inadequate chewing, poor bite size control, choking, inadequate control of liquids, etc.) _____

List a few of your child's favorite snacks _____

Handedness: Right Left Undetermined

Fine motor skills (using scissors, coloring, writing, pencil grasp) _____

Is your child toilet-trained _____ In process _____

Any difficulties _____

Is your child overly sensitive to touch, noise, clothing, brushing teeth? _____

Describe any unusual or repetitive behaviors _____

SPEECH-LANGUAGE HISTORY

At what age did your child:

Begin to babble _____

Say first words _____

Begin putting two words together _____

Use longer sentences _____

First imitate sounds _____ words _____

Did this child seem unusually quiet as a baby? _____

How does your child typically let you know what he/she wants?

- Cries
- Points to what he/she wants
- Uses gestures
- Makes a few sounds
- Makes many different sounds
- Uses a few words
- Uses many words, but only uses one at a time
- Uses 2-3 word sentences
- Uses long sentences

Does your child:

- Turn and look when you talk to him/her?
- Answer or respond verbally?

Patient History

- Use a word, lose it and then learn a new word, etc.
- Talk about what he/she is doing or sees?
- Ask for help?

- Understand a few words
 many words and phrases
 simple directions
 almost everything I say

Does this seem age-appropriate to you? _____

How much do you understand of what your child says? _____

How much do others understand? _____

How does your child react when other's do not understand? _____

Does you child's speech seem to be improving? _____

Additional comments (examples of sounds or words your child says if limited) _____

Does your child experience any of the following:

- Whole word repetitions
- Sound prolongations
- Syllable repetitions
- Sound repetitions
- Total blocking of sound when trying to talk

If so, how long has this been occurring: _____ How frequently? _____

What has been your response to this difficulty? _____

How has your child reacted? _____

SOCIAL SKILLS

Does your child prefer to play:

- alone
- with younger children
- with older children
- with same age children

How many hours a day does your child watch television/videos/computer? _____

List a few of your child's favorite toys/activities _____

Describe your child's disposition, personality, what he/she enjoys, etc. _____

What are your child's strengths? _____

What are your frequent discipline problems with your child? _____

What forms of discipline have you used and what seems to be the most effective?

What else would you like me to know about your child or family? _____
