

## Patient History Form

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

REFERRAL SOURCE: \_\_\_\_\_

DATE OF EVALUATION: \_\_\_\_\_

Dear Parent/Guardian:

Please answer questions to the best of your knowledge. I recognize that it is lengthy. The information that you supply is valuable information, resulting in the best treatment plan and/or recommendations for your child.

Thank you,

### Initial information

Who referred you to the clinic? \_\_\_\_\_

What is your child's doctors name? \_\_\_\_\_

Describe in your own words the problem your child is having with speech, language and/or hearing? \_\_\_\_\_

When did you first notice the problem? \_\_\_\_\_

Who noticed the problem? \_\_\_\_\_

### Developmental History

Was your child full term? \_\_\_\_\_

Was your child preterm? Yes No If so how many weeks/months? \_\_\_\_\_

What medications were used during pregnancy? Please explain why. \_\_\_\_\_

Did you have any complications during your pregnancy? \_\_\_\_\_

Was the delivery normal? \_\_\_\_\_

Length of labor? \_\_\_\_\_

Vaginal or Caesarian delivery? \_\_\_\_\_

Any complications at birth? Please describe. \_\_\_\_\_

\_\_\_\_\_

Were any structural abnormalities noted at birth (cleft lip, torticollis, etc.)? \_\_\_\_\_

\_\_\_\_\_

How long were you and the child in the hospital? \_\_\_\_\_

Birth weight? \_\_\_\_\_ APGAR? \_\_\_\_\_

Has your child had any surgeries or history of serious illness? Please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Breast or bottle fed? \_\_\_\_\_ For how long? \_\_\_\_\_

Did your child take a pacifier or thumb? \_\_\_\_\_ For how long? \_\_\_\_\_

How was feeding? \_\_\_\_\_

Please describe any complications or problems that you noticed? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What types of foods does your child like to eat at this time? \_\_\_\_\_

\_\_\_\_\_

Do you find your child to be a picky eater or resistant to new textured foods? If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

Have you established a toothbrushing routine? Yes No How does your child respond? \_\_\_\_\_

\_\_\_\_\_

Does your child drink from a cup? Yes No What type sippy, straw, regular? \_\_\_\_\_

Does your child cough when eating or drinking? Please describe. \_\_\_\_\_

\_\_\_\_\_

At what approximate age did your child sit \_\_\_\_\_, crawl \_\_\_\_\_, walk \_\_\_\_\_,  
become toilet trained? \_\_\_\_\_

Are immunizations up to date? \_\_\_\_\_

### **Hearing History**

Has your child had ear infections? \_\_\_\_\_

How many ear infections? \_\_\_\_\_

How were they treated (tubes, antibiotics)? \_\_\_\_\_

If treated with tubes, how many sets has your child had? \_\_\_\_\_

How long do the tubes usually last? \_\_\_\_\_

How many courses of antibiotics were needed to clear the infection? \_\_\_\_\_

Does your child have a history of fluid with no infection? \_\_\_\_\_

Has your child been diagnosed with eustachian tube dysfunction? \_\_\_\_\_

Are you concerned about your child's hearing? \_\_\_\_\_

Is your doctor concerned about your child's hearing? \_\_\_\_\_

Has your child's hearing been tested? If so where and when? \_\_\_\_\_

### **Speech and Language History**

**On your first appointment, please bring any previous evaluations and or screening information.**

Has your child had a previous speech and language evaluation/screening? Yes No Where was this  
evaluation done and by whom? \_\_\_\_\_

Has your child participated in previous speech and language therapy? Yes No Where did/does this  
therapy take place and by whom? \_\_\_\_\_

Has anyone in your family had speech and language difficulties? \_\_\_\_\_

\_\_\_\_\_

**Speech Language and Hearing Development**

**If your answer is “yes” on any of the questions please give an example.**

Did your child make babbling and cooing sounds during the first 6 months of life? \_\_\_\_\_

\_\_\_\_\_

Did your child babble or coo to your initiation or babble and coo when left alone? \_\_\_\_\_

\_\_\_\_\_

At what age was your child’s first word? \_\_\_\_\_

What were the first words? \_\_\_\_\_

Did your child keep adding words once he/she started to talk? \_\_\_\_\_

Is your child combining words? Two word, three word combinations? \_\_\_\_\_

Did your child’s speech ever stop for a period of time? \_\_\_\_\_

How does your child communicate? (Mostly gestures, mostly noises with gestures, screaming and crying with gestures, one word and gestures, 2 words, 3 words or full sentences.) \_\_\_\_\_

\_\_\_\_\_

Does your child make sounds incorrectly? Yes No What are they? \_\_\_\_\_

Can family and friends understand your child? \_\_\_\_\_

Does your child get stuck, stutter or repeat words or sounds? \_\_\_\_\_

Can your child say nursery rhymes or tell a short story? \_\_\_\_\_

\_\_\_\_\_

Does your child understand what is being said to him/her? \_\_\_\_\_

Can your child follow directions? \_\_\_\_\_

Does your child have trouble remembering what you have told him or her? \_\_\_\_\_

\_\_\_\_\_

Do you see your child as being frustrated by his/her communication style? \_\_\_\_\_

\_\_\_\_\_

What do you do when you cannot understand the message your child is giving you? \_\_\_\_\_

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Have you noticed any changes in your child's communication in the recent weeks or months? \_\_\_\_\_

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Is your child interested in books? Yes No Do you have a book time at home? Yes No

Does your child attend playgroups/daycare/preschool? Where? How often? \_\_\_\_\_

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Is it a highly structured or unstructured environment? \_\_\_\_\_

How does your child interact with peers? \_\_\_\_\_

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Does your child prefer to play alone or with others? \_\_\_\_\_

What are some of your child's favorite activities? \_\_\_\_\_

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Has your child participated in any other therapy (occupational, physical, vision therapy, etc.)? \_\_\_\_\_

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Has any other specialist (physician, psychologist, special education teacher, etc.) seen your child? If yes, indicate the type of specialist, when your child was seen, and the specialist's conclusions or suggestions. \_\_\_\_\_

**Thank you for your time.**