



## 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: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Education Completed: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Education Completed: \_\_\_\_\_

Languages spoken in the home: \_\_\_\_\_ Primary language \_\_\_\_\_

**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? \_\_\_\_\_

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)*

Why are you bringing your child to see us today?

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### **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:

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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**

In early childhood, did the child have any feeding problems (such as poor control of sucking, food allergies, digestive upsets)?  Yes  No

If yes, please describe: \_\_\_\_\_

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

### MEDICAL HISTORY

Date and type of last medical examination \_\_\_\_\_

List ages for any of the following childhood diseases:

Whooping cough \_\_\_\_\_ Pneumonia \_\_\_\_\_  
Mumps \_\_\_\_\_ Chicken Pox \_\_\_\_\_  
Measles \_\_\_\_\_ Tonsillitis \_\_\_\_\_  
Rheumatic fever \_\_\_\_\_ Other: \_\_\_\_\_

Were there any complications with any of the above, such as high/persistent fevers, convulsions, or persistent muscle weakness?  Yes  No

If yes, please explain: \_\_\_\_\_

Is the 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:

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### EDUCATION HISTORY

Current School \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Did the child attend nursery school?  Yes  No

If yes, when? From age \_\_\_\_\_ to age \_\_\_\_\_

At what age did the child attend kindergarten? \_\_\_\_\_

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)

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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:

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**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?  Yes  No to friends?  Yes  No

to strangers?  Yes  No to other family members?  Yes  No

List sounds or words that the child has trouble saying

\_\_\_\_\_

How does the child compare with siblings 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):

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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?

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Do you have any further questions?

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Patient or Parent/Guardian Signature

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Relationship to Patient

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Date