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: ______________________________

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?

____

____

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, other illnesses, drugs or medications)?

☐ 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

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:

____

____

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)

____

____

____

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? ☐

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):

____

____

____

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