PATIENT HISTORY

Patient Name: ___________________________ Date of Birth: ______________ M___F___

Parent 1 Name: __________________________ Parent 2 Name: __________________________

Email:__________________________________ Email: __________________________________

Cell: ___________________________________ Cell: ___________________________________

Address: ________________________________ Home Phone: ___________________________

____

School: ____ Grade: __________
Name City State

Pediatrician: ____
Name Town Phone

Areas of concern/reason for evaluation: ____

____

Whose idea was it for the child to be evaluated? ____

Is English the primary language spoken at home? ☐ Yes ☐ No
If No, what is the primary language spoken at home? _____________________
What languages does the child speak? __________________________________
What languages does the child understand? _____________________________

Family History:

	Parent 1	Parent 2
Name		
Age		
Occupation		
Highest Grade Completed		
Learning Problems (Specify)		
Medical Problems (Specify)		

Siblings: Name Age Speech/Language Problems

____
____
____

Parents are: Married ________ Divorced ___________

If Divorced, Child lives with: Parent 1 Parent 2

Birth Information:

Is this child biological or adopted? __________________

If adopted, please provide adoption information (date, location, important information)

____
____
____

Age of biological mother at birth: ______________ Length of Pregnancy: ________________________

Were there any complications at birth? ☐ Yes ☐ No

If yes, describe: ____

Weight at Birth: _____________

Went home after ____________ day(s) in hospital

Early Development:

Enjoyed Cuddling ☐ Yes ☐ No

Problems with feeding/sucking/swallowing ☐ Yes ☐ No

Fussy/Irritable ☐ Yes ☐ No

More active than other babies ☐ Yes ☐ No

Other: ____

Oral Motor Skills:

Chewing difficulties ☐ Yes ☐ No

Excessive drooling ☐ Yes ☐ No

Thumb sucking ☐ Yes ☐ No If yes, how long? __________________

Pacifier use ☐ Yes ☐ No If yes, how long? __________________

Food preferences ☐ Soft ☐ Hard ________________________________

Developmental History:

Please state the approximate age your child achieved the following developmental milestones:

Babbled _______ Sat alone _______

Said First Words _______ Walked ________

Put two words together ________ Grasped Crayons/Pencils _______

Spoke in short sentences ________ Toilet Trained _______

Please list any difficulties: ____

Your child currently communicates using:

- ☐ body language (pointing, gestures)
- ☐ sounds (vowels, grunting)
- ☐ single words (shoe, doggy, up)

- ☐ 2 to 4 word phrases
- ☐ sentences longer than 4 words
- ☐ Other: ____

Does your child:

- ☐ repeat sounds, words or phrases over and over?
- ☐ understand what you are saying?
- ☐ retrieve/point to common objects upon request (ball, cup, shoe)?
- ☐ follow simple commands ("shut the door" or "get your shoes")?
- ☐ respond correctly to yes/no questions?
- ☐ respond correctly to who/what/where/when/why questions?

Medical History:

Has your child had any of the following?

☐ Adenoidectomy	☐ Flu	☐ Scarlet Fever
☐ Breathing difficulties	☐ Headaches	☐ Seizures
☐ Chicken Pox	☐ Head Injury	☐ Sinusitis
☐ Colds	☐ High Fevers	☐ Thumb Sucking
☐ Ear Infections How often? ___________	☐ Measles	☐ Tonsillectomy
☐ Ear Tubes Date _________________	☐ Meningitis	☐ Tonsillitis
☐ Encephalitis	☐ Mumps	☐ Vision Problems

Does your child have any allergies? If so, to what? ____

Please list any medications your child takes regularly? ____

List any other health problems ____

Social History:

What toys/interests does your child enjoy? ____

Does your child:

Play well with peers?	Y	N
Have difficulty attending?	Y	N
Transition easily?	Y	N
Enjoy reading activities?	Y	N

Does your child have difficulty with:

Separation	Y	N
Sitting Still	Y	N
Changes in routine	Y	N
Following directions	Y	N

Is your child sensitive to sound, touch and/or textiles? Y N _____________________________

School History:

How does your child perform in school? ____

____

Previous testing your child has had (i.e. speech/language; neurological; psychological, etc.):

Type of testing: ____
When: ____
Where/By Whom: ____

Has your child received special education services at school? Y N Type: ______________
If yes, is your child currently on an educational plan? Y N

What services does your child currently receive?

		Frequency (times/week and duration):	School or Private
____	Speech Therapy	_________________________________	___________________
____	Occupational Therapy	_________________________________	___________________
____	Physical Therapy	_________________________________	___________________
____	Special Ed/Reading	_________________________________	___________________

Name of Individual Completing This Form: ____

Relationship to Patient: ____

Date: _______________________________