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Patient History Form

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:** ________

Father's Name: ______________________________ **Age:** ________

Address: ______________________________

City: ______________ **State:** ________ **Zip:** ________

List all children in the family from oldest to youngest:

Name	Age	Sex	Grade in School	General Health

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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 ____________________

BIRTH HISTORY

Pregnancy: ☐ Normal ☐ Abnormal/Complications (explain) ____________________

____

Length of Pregnancy ______ Premature: ☐ No ☐ Yes

Birth weight: ____lbs. ____ oz.

List any complications at delivery? ____________________

Did the child experience any complications immediately following birth? ☐ No ☐ Yes (explain):

____

DEVELOPMENTAL HISTORY

In early childhood, did the child have any feeding/swallowing problems (such as poor control of sucking, food allergies, and 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

EDUCATION HISTORY

Current School: ____________________

Grade: ____________________

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:

____

____

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DAILY BEHAVIOR

Are you concerned with your child's social skills? ☐ Yes ☐ No

Is your child aware of the speech/language difficulties he/she is having? ☐ Yes ☐ No

Does the child prefer to play alone? ☐ Yes ☐ No

Does the child have a close friend? ☐ Yes ☐ No

Does the child prefer to play with older or younger children? ______________________

Does the child have difficulty concentrating? ☐ Yes ☐ No

Describe how your child interacts with his/her peers:

____

____

How do you discipline?

____

____

What are your most frequent discipline problems with this child?

____

____

MEDICAL HISTORY

Is the child currently taking any medications? ☐ Yes ☐ No

If yes, please describe: ______________________

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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COMMUNICATION HISTORY

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? ____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Which language does the child prefer to speak at home? ______________________________

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

____

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
(Printed Name Will Count as Signature)

____

Relationship to Patient

____

Date

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