



Synaptic Pediatric Therapies

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Patient History Form

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Person Completing This Form: _____

Relationship to Client: _____

Parent's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent's Occupation: _____

Has the child or any member of the family been tested positive for COVID-19? Yes No

Who lives in the home with the child? _____

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: _____

BIRTH HISTORY

Pregnancy: Normal Abnormal / Complications (explain): _____

Length of Pregnancy: _____ Premature: Yes No

Birth weight: _____ lbs. _____ oz.

Delivery was: Vaginal C-Section Emergency C-Section

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 food _____	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:

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?

Description of Child:

- Active Affectionate Aggressive Calm Cautious Curious Demanding
 Difficult to Comfort Distractible Fearful Fearless Fussy Insecure Motivated
 Passive Persistent Playful Shy Stubborn Withdrawn

MEDICAL HISTORY

Does your child have any medical diagnosis/conditions? Yes No

If yes, please list or describe diagnosed or suspected conditions: _____

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 so, 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: _____

COMMUNICATION HISTORY

What is your primary concern? (Please check what applies)

- Articulation - Difficulty saying sounds in words clearly or correctly; difficult to understand.
- Language - My child has difficulty following directions, answering questions, and/or difficulty or limited use of words, sentences and/or grammar to communicate wants or tells stories.
- Fluency - My child stutters, repeats sounds/words, and has speech that is halting and not fluid.
- Voice - My child has a hoarse/breathy voice and/or is too quiet or loud.
- Feeding - My child is a very picky eater, only eats a limited number of foods, only eats certain texture, coughs/chokes on food or liquids, and/or has poor weight gain/growth.
- Other (please specify any other concerns):

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:

Please give ages of development for the following behaviors:

Babbled: _____ 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?

My child prefers to communicate via:

- | | |
|--|---|
| <input type="checkbox"/> Body Language | <input type="checkbox"/> Augmentative Communication |
| <input type="checkbox"/> Eye Gaze | <input type="checkbox"/> Vocalization |
| <input type="checkbox"/> Facial Expressions | <input type="checkbox"/> Single Words |
| <input type="checkbox"/> Manual Sign Language | <input type="checkbox"/> Phrases |
| <input type="checkbox"/> Pointing/Gesturing | <input type="checkbox"/> Sentences |
| <input type="checkbox"/> Picture Communication | |

Do you have any further questions?

Patient or Parent/Guardian Signature
(Printed Name Will Count as Signature)

Relationship to Patient

Date