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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:

☐	Body Language	☐	Augmentative Communication
☐	Eye Gaze	☐	Vocalization
☐	Facial Expressions	☐	Single Words
☐	Manual Sign Language	☐	Phrases
☐	Pointing/Gesturing	☐	Sentences
☐	Picture Communication		

Do you have any further questions?

_____

_____

_____

_____

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

_____

Relationship to Patient

_____

Date