Play to Talk
SPEECH THERAPY

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, RH negative, German measles, other illnesses, drugs or medications, previous miscarriages)?

☐ 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