WestField Speech Solutions PLLC

PATIENT HISTORY

Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Person Completing This Form: _____

Relationship to Client: _____

Does the child live with both parents? _____

Mother's Name: _____ Age: _____

Address: ☐ *Same as above* ☐ *Other:* _____

Mother's Occupation: _____

Education Completed: _____

Father's Name: _____ Age: _____

Address: ☐ *Same as above* ☐ *Other:* _____

Father's Occupation: _____

Education Completed: _____

List all children in the family from oldest to youngest

Name	Age	Sex	Grade in School	General Health

(continues)

Who referred you for the evaluation? _____

Child's pediatrician or family doctor _____

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)

Describe the child's speech-language problem:

COMMUNICATION HISTORY

What languages does the child speak? What is the child's dominant language?

What languages are spoken in the home? What is the dominant language spoken?

With whom does the child spend most of his or her time?

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, if any (not sentences that are repeated after you):

Does the child seem to understand directions? ☐ Yes ☐ No

How does the child usually communicate (gestures, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

(continues)

What do you think may have caused the problem?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does he or she feel about it?

Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions?

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Are there any other speech, language or hearing problems in your family? *If yes, please describe*.

PRENATAL AND BIRTH HISTORY

Weight of child at birth _____ Was the child full term? ☐ Yes ☐ No

Were there any conditions that may have affected the pregnancy or birth (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 # *of 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: _____

Please provide the approximate age at which the child began to do the following activities:

Sitting unsupported	_____	Walking	_____
Eating solid foods	_____	Self-feeding	_____
Crawling	_____	Self-dressing	_____
Standing alone	_____	Bladder/bowel control	_____

If applicable, please provide the approximate age at which the child began to:

Use single words (e.g., no, mom, doggie)	_____
Combine words (e.g., me go, daddy shoe)	_____
Name simple objects (e.g., dog, car, tree)	_____
Engage in a conversation	_____

Do you feel that the child was late or had difficulty in developing any of these behaviors?

☐ Yes ☐ No

(continues)

Does the child have difficulty walking, running or participating in other activities that require small or large muscle coordination? If yes, describe.

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing)? If yes, describe.

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds).

MEDICAL HISTORY

Date and type of last medical examination _____

List approximate ages for any of the following childhood diseases:

Asthma	_____	Chicken Pox	_____	Colds	_____
Croup	_____	Dizziness	_____	Draining Ear	_____
Ear Infections	_____	Encephalitis	_____	German Measles	_____
Headaches	_____	High Fever	_____	Influenza	_____
Mastoiditis	_____	Measles	_____	Meningitis	_____
Mumps	_____	Pneumonia	_____	Seizures	_____
Sinusitis	_____	Tinnitus	_____	Tonsilitis	_____

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: _____

(continues)

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:*

Has the child had any surgeries? ☐ Yes ☐ No *If yes, please explain:*

Describe any major accidents or hospitalizations

Is the child taking any medications? ☐ Yes ☐ No *If yes, please identify:*

Have there been any negative reactions to medications? ☐ Yes ☐ No *If yes, please identify:*

EDUCATION HISTORY

Current School _____

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:

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? *If yes, describe the goals.*

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

Describe the child's interactions when he or she plays with others (e.g., shy, aggressive, etc.)

_____

_____

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? _____

Do you have any additional information that might be helpful in the evaluation or remediation of the child's problem?

Do you have any particular questions you would like the Speech-Language Pathologist to address?

Parent/Guardian Signature

Relationship to Patient

Date