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PEDIATRIC PATIENT HISTORY FORM

GENERAL INFORMATION

Child's name: ______________________________ Date: ______________
First Middle Last

Form completed by: ______________________ Relationship to child: ______________

Gender of child: Male _____ Female _____ Birth date of child: ______________ Age: _______

Address: ____
Number and Street City, State, Zip Daytime Phone

Language(s) other than English spoken at home/childcare: ______________________

Primary language(s) spoken by child: ________________; understood by child ____________

Current Pediatrician or Family Doctor:

Name: ______________________ Telephone: ______________________

Who referred you to us:____

PREVIOUS/OTHER EVALUATIONS

Has your child ever been examined by any of the following professionals: (please add any not listed)

PROVIDER	Dates of Exam/Eval	Name of Provider	Currently under care?	Results
Audiologist				
Behavior Specialist				
Developmental Pediatrician				
Diagnostician				
Neurologist				
ECI				
ENT				
Occupational Therapist				
Ophthalmologist				
Physical Therapist				
Psychologist				

Social Worker				
Speech Pathologist				
School District Specialist(s)				

Diagnostic/Laboratory Tests: Has your child had any of the following procedures? (Please add any additional tests if not listed.)

Test	Date	Reason for test	Ordered/Performed By	Results
EEG (brain activity)				
EKG (heart activity)				
CT Scan				
MRI				
Genetic testing				
Swallow Function Study (MBS)				
Microarray analysis				
Bloodwork (not routine)				

Has your **child** or **any family member** been diagnosed with any of the following:

Yes	Diagnosis	Relationship to Child
	ADD/ADHD	
	Anxiety	
	Autism Spectrum Disorder	
	Cleft Palate or Lip	
	Chronic Ear Infections	
	Fine Motor Delays/Issues	
	Genetic Syndrome/Disorder	
	Gross Motor Delays/Issues	
	Hearing Problem	
	Intellectual Disability	
	Learning Disability	
	Psychosocial Disorders	
	Sensory Processing Disorder	
	Speech or Language Problem	

AREAS OF CONCERN

What are the reasons for your child's referral to Speech & Motion Therapy?

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____
____
____
____

At what age were these problems first recognized and by whom?

____
____
____
____
____

What are your main goals/concerns that you want speech and/or occupational therapy to address?

____
____
____
____
____

FAMILY HISTORY

Child currently lives with: (please check all that apply)

	Natural Mother		Natural Father		Grandmother		Foster Mother
	Stepmother		Stepfather		Grandfather		Foster Father
	Adoptive Mother		Adoptive Father		Other:		Other:

If adopted list child's age at adoption, date of adoption, and other known details:____
____

Names of Household Members	**Age**	**Gender (M/F)**	**Relationship to Child**	**Living in Household (Yes/No)**

BIRTH HISTORY

Pre-Natal History: Please indicate which of the following conditions occurred during this pregnancy and explain (month, amount, treatment, etc.) in space below:

	Alcohol used		Infections (flu, UTI, etc…)
	Cigarettes used		Injuries
	Cocaine used		Marijuana used
	Diabetes		Medications used:
	Edema (hand/feet swelling)		Other drugs used:
	Emotional stress		Other Illnesses:
	Epilepsy (seizures)		Surgeries:
	Fever		Toxemia
	High blood pressure		Vaginal bleeding
	Hospitalization:		X-ray studies
	Other:		Other:

Further explanation of checked answers:
____
____
____

Delivery History:

Length of pregnancy: ________________ Length of labor: __________________

Age of mother at birth: _____ Age of father at birth: _____ Weight of child at birth: _____________

Type of birth:

	Spontaneous vaginal		Induced vaginal		C-section

Baby's presentation:

	Breech		Head		Transverse (sideways)

Please indicate if any of the following problems occurred during/after labor:

	Toxemia/eclampsia		Fetal distress:
	Maternal fever		Medications used:
	Maternal distress:		Other:

Further explanation of checked answers: ____

____

____

Post Delivery History: Please indicate if any of the following problems occurred after the child's birth and explain the amount and treatment in the space below:

	Blood transfusion		Infection
	Cord around neck		Jaundice
	Cyanosis (turned blue)		Poor feeding skills
	Fever		Poor muscle tone
	Hemorrhage (bleeding) in head		Trouble breathing
	Hydrocephalus (fluid on brain)		Ventilator use
	Incubator care		Vomiting/reflux
	Other:		Other:

Further explanation of checked answers: ____

____

____

Number of days infant stayed in the hospital after delivery? ______________________

Infant Hearing Screening results (if known):_____________________________________

Infancy History: Please indicate if any of the following characteristics were present in your baby to a significant degree during the first few years of life.

	Did not enjoy cuddling		Excessive restlessness
	Difficult to comfort		Frequent head banging
	Difficulty feeding		Sleeping difficulties
	Excessive irritability		Was not calmed by being held, rocked, stroked
	Extremely passive		Other:

Further explanation of checked answers: ____

____

____

MEDICAL HISTORY

✓	**Disorder**	**Age**	**Date or Frequency**	✓	**Disorder**	**Age**	**Date or Frequency**
	Accidental poisoning				Measles		
	Adenoidectomy				Meningitis		
	Allergies (seasonal)				Mumps		
	Anemia				Other infections		
	Asthma				PE tubes		

	Bed wetting				Persistent high fever		
	Constipation/Diarrhea				Pica (eat nonfood items)		
	Cerebral Palsy				Pneumonia		
	Chicken Pox				Poor muscle tone		
	Colds				Reflux		
	Concussion				Seizures		
	Coma				Sinusitis		
	Croup				Sleep problems		
	Diabetes				Staring spells		
	Ear infections				Stomach aches		
	Encephalitis				Stitches/lacerations		
	Excessive vomiting				Surgery		
	Falls frequently				Tics		
	Flu				Tonsillitis		
	Headaches				Tonsillectomy		
	Head injury/trauma				Trauma (broken bones)		
	Hospitalizations				Tremor		
	Lost consciousness				Other Medical Problems		

Further explanation of checked answers: ____

____

____

Allergies:

Does your child have any known skin allergies, including allergies to latex? Yes _____ No _____
Please list all known skin allergies:

____

____

Does your child have any known food allergies? Yes_____ No_____
Please list all known food allergies: ____

____

Does your child have any known allergies to medications? Yes_____ No_____
Please list all known allergies to medications: ______________________________________

____

Is your child currently taking medication? Yes_____ No______

Medication	Dosage	Frequency	Start date	Reason for Taking

Hearing/Vision:

Date of last vision exam: ________________ Location: ____________________________________

Vision problem? Yes ______ No ______ Type of vision problem:_____________________________

Has the following: Unaided _______ Glasses _______ Contacts _______

Date of last hearing exam: _______________ Location: ____________________________________

Hearing problem? Yes _____ No _____ Type of hearing problem: _____________________________

Has child ever used: Hearing Aids _____ FM System _____ Cochlear Implant _____

Has your child ever been diagnosed with an auditory processing disorder? Yes _____ No _____ If "Yes" by whom?

____

Do you question your child's ability to understand directions or conversations? Yes _____ No _____

Listening Habits:

Is child able to:	**YES**	**NO**
Hear on the telephone		
Hear radio/stereo/TV		
Hear one-on-one		
Hear in groups		
Understand in quiet		
Understand in noise (teacher's directions)		
Locate direction of sound		

DEVELOPMENTAL HISTORY

Speech/Language Milestones: Please list the approximate age your child:

***Write **N/A** for skills above your child's age expectation and **SW** if your child is still working on a skill.

Produce first word		Talk in sentences	
Name simple objects		Answer simple questions	
Combine two words		Engage in conversation	

Did your child's speech/language development seem to stop? Yes__________ No___________ If "Yes", When? _______________

Speech/Language Skills:

What is the primary method(s) your child uses for letting you know what he/she wants? (Please check)

	Looking at objects		Pointing at objects		Gestures
	Crying		Vocalizing/grunting		Physical manipulation
	Single words		2-3 words		Sentences

Which of the following best describes your child's speech? (Please check)

	Easy to understand
	Difficult for parents to understand
	Difficult for others to understand
	Almost never understood by others

Is your child aware of his/her communication difficulties? Yes________ No_________
If "Yes", how does this awareness impact your child's social/emotional status?

____

____

Does your child have difficulty producing certain sounds? Yes_______ No_________
If "Yes", which ones?____

Does your child "get stuck" when attempting to say a word? Yes_______ No________

Do you have concerns about your child's voice? Yes________ No__________

Which of the following do you think you child understands? (check all that apply)

	His/her own name		Names of body parts		Family names
	Names of objects		Simple directions		Complex directions
	Conversational speech		Yes/no questions		

Motor Skills & Self-Care Milestones: Please list the approximate age your child was able to:

***Write **N/A** for skills above your child's age expectation and **SW** if your child is still working on a skill.

Sit independently		Toilet trained (bladder)	
Crawl independently		Toilet trained (bowels)	
Stand independently		Pedal a 3-wheeler	
Walk independently		Pedal a 2-wheeler	
Feed self w/ utensils		Scribble on paper	
Drink from open cup		Write his/her name	
Undresses independently		Cut w/ scissors	
Dresses independently		Throw a ball	
Snaps, zips, buttons clothing		Catch a ball	
Take off socks/shoes		Kick a ball	

Put on socks/shoes		Jump up with feet leaving floor	
Ties shoes			

*Check any skills you want evaluated and/or addressed in therapy

Eating Habits: Please check any of the following feeding difficulties your child had or currently has.

	Sucking or nursing
	Excessive length of time to drink bottle
	Regurgitation of liquids or solids through the nose
	Transitioning from bottle to baby foods
	Transitioning from pureed textured food
	Difficulty chewing or swallowing meals
	Choking and/or gagging
	History of aspiration
	Reflux
	Tube feeding (NG, OG, or G-tube)
	Excessive drooling

How would you rate your child's appetite? Poor _____ Fair _____ Good _____ Excellent _____

Is your child a picky eater? Yes _____ No _____ Sometimes _____

If so, what will your child eat?

____

____

____

What foods does your child avoid?

____

____

____

Does your child still have a pacifier? Yes__________ No__________

Does your child still suck his/her thumb? Yes_________ No_________

What utensils does your child use independently?

	Fingers		Knife
	Spoon		N/A
	Fork		

How does your child take in liquid?

	Bottle		Straw
	Sippy Cup		Other:
	Cup		

Sleeping Habits:

Where does your child sleep?

	Own bedroom
	Bedroom parent(s) sleep in
	Bedroom shared with 1 2 3 4 5 or more (not parents) Specify with whom:

Does your child have problems falling asleep? Yes _____ No _____

Does your child wake up in the middle of the night? Yes _____ No _____

How many hours per night does your child sleep? _______________

Behavior:

Please describe briefly any behavioral problems at school, home, or other settings:

____
____
____
____
____

Please check any of the following behaviors that your child displays frequently or intensively.

	Anxiety		Irritability		Physical aggression
	Attention seeking		Lack of confidence		Repetitive behavior
	Avoidant behaviors		Laziness		Short attention span
	Clumsiness		Low frustration tolerance		Shyness
	Crying episodes		Low self-esteem		Sleep problems
	Defiance		Memory loss		Social isolation
	Distractibility		Noncompliance		Temper tantrums
	Falling		Obsessive compulsive		Unhappiness
	Hyperactivity		Oppositional behavior		Unusual fears
	Impulsivity		Poor concentration		Unusual interests

Please provide additional information about any of the above you feel would be helpful:

____
____
____
____
____

Have any of the following events occurred within the past 12 months?

	Parents divorced or separated		Death in the family		Child changed schedule
	Family accident or illness		Family moved		Change in teacher
	Family financial problems		New baby at home		Change in school
	Parent changed jobs		Conflict in family		Other stressor:

Please explain:
____
____

Social Skills:

What does your child enjoy doing most? (Home, school, and play/social settings.)

____
____
____

What does your child dislike doing most? (Home, school, and play/social settings.)

____
____
____

Does your child make friends easily? Yes _____ No _____

Does your child get along well with others? Yes _____ No _____ Sometimes _____

Does your child get along best w/: Older children ____ Same age children ____ Younger children ____

EDUCATION

Name of child's current school: ____
School district: ______________________________I.S.D.
Address of school: ____
Telephone: ______________________ Grade: _____ Teacher: ___________________

Class placement: Regular class _____ Special class (specify) _____ Bilingual _____ ESL _____

Has your child ever been retained? No _____ Yes _____ What grade?______
Why?____
Briefly describe your child's academic performance:
____
____
____

Has your child ever been in any of the following programs or received any of these services in school, and if so, how long?

✓	**Program/Service**	**Age**	**Start Date/ Frequency**	✓	**Program/Service**	**Age**	**Start Date/ Frequency**
	PPCD				Speech Therapy		
	ECI				Occupational Therapy		
	ABA				Physical Therapy		
	Resource Room Services				Adapted Physical Education		
	Life Skills Class				Counseling		
	Content Mastery				Self-Contained Class		
	Gifted and Talented				Other:		

Have any instructional modifications been attempted? Please check all that apply.

	Oral tests		Extended time		Reduced written work
	Additional instructions		Shortened Assignments		Repeated review
	Manipulatives in math		Study sheets		Study carrel
	Preferential Seating		Peer teaching		Outlines
	Study sheets		Control of distractions		Behavior modification program
	Positive reinforcement		Behavior chart/cards		Predictable routines
	Increased positive feedback		Tech Assistance		Other:

Please write any additional remarks you may have regarding your child or address any area or concern we may have missed in the space provided:
____
____
____
____
____
____
____

Parent Signature:____**Date:**____________

RELEASE OF INFORMATION

I, ______________________ give my written permission for Speech and Motion Therapy to
(Parent's name)
Contact/release medical, speech, and occupational therapy information regarding my child,

_________________________, To:
(Child's name)

- ❑ Primary Care Physician/Pediatrician ________________________________
  (Name)
  Phone number:____
- ❑ Other Physician (ENT, Neurologist, etc.) ____________________________
  (Name)
  Phone number:____
- ❑ Teacher ________________________
  (name)
  Phone number:____
- ❑ Other (insurance company) __________________________
  (Name)
  Phone number:____

______________________________ ______________________________
Signature **Name (print)**

______________________________ ______________________________
Relationship to Client **Date**

__________________________________ ______________________________
Address **Phone**