TOTAL Pediatric THERAPY

Physical • Occupational • Speech

SPEECH THERAPY PATIENT HISTORY

PATIENT HISTORY

Child's Full Name :

Child's Age : **Born Full Term :** ☐ Yes ☐ No **If no, what gestational age?**

Did your child require any advanced medical care upon birth? ☐ Yes ☐ No

If yes, please describe:

List any complications during pregnancy:

HOME ENVIRONMENT

Who lives at home with the child? (Siblings (ages), mother, father, step-parents, grandparents, etc):

How often Is English spoken In the home? ☐ Always ☐ Most of the Time ☐ Sometimes ☐ Never

If another language is spoken, what language(s) is/are used in the home?

Any special home circumstances?

Parents Relationship ☐ Married ☐ Divorced ☐ Joint Physical Custody ☐ Child Adopted ☐ Other ____

Any cultural or religious considerations for therapy? (holiday celebrations, prohibitions, etc)

EDUCATION

How Is your child currently educated: ☐ E-Learning ☐ Pre-School/School ☐ Home School

What is your child's current grade level? **Has your child ever been held back a grade?** ☐ Yes ☐ No

What subjects In school Is your child on grade level for? ☐ Reading ☐ Math ☐ Science ☐ Social Studies

Does your child receive special education services? ☐ Yes ☐ No

Does your child have an IEP or IFSP? ☐ Yes ☐ No

If yes, what Is It targeting?

MEDICAL HISTORY

Has your child ever had any of the following:

- ☐ Frequent Ear Infections
- ☐ Early Intervention
- ☐ Speech Therapy
- ☐ Allergies (List Below)
- ☐ Hearing Problems
- ☐ Occupational Therapy
- ☐ Tubes in Ears
- ☐ Physical Therapy
- ☐ Head Injury
- ☐ Developmental Delay
- ☐ Behavior Therapy
- ☐ Premature Birth
- ☐ Hospitalization

Please provide further explanations for Items checked above:

List current medications:

Is your child diagnosed with any Developmental or Sensory disorders?

- ☐ Language Disorder
- ☐ Social Communication Disorder
- ☐ Dyslexia
- ☐ Articulation Disorder
- ☐ Stuttering
- ☐ Sensory Processing Disorder
- ☐ ADHD
- ☐ Anxiety
- ☐ Autism
- ☐ Intellectual Disability
- ☐ Fragile X Syndrome
- ☐ Degenerative Condition
- ☐ Blind
- ☐ Deaf/Hard of Hearing
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Learning Disorder
- ☐ Other (list below)

Please provide further explanations for any of the checked Items above:

Do you suspect your child has any undiagnosed disorders? ☐ Yes ☐ No

If yes, please explain:

COMMUNICATION

When was their most recent hearing test done? **Vision Screening?**

Did your child have difficulties with feeding after birth?

Breast ☐ Yes ☐ No **Bottle** ☐ Yes ☐ No

If yes, please explain:

Does your child currently have any swallowing diculties/excessive coughing or choking when eating or drinking?

☐ Yes ☐ No

If yes, please explain:

Which of the following areas of communication do you feel your child may need speech therapy to improve? (check all that apply)

- ☐ Understanding Language
- ☐ Fluency/Stuttering
- ☐ Expressing Language
- ☐ Social Communication
- ☐ Speech Sounds
- ☐ Voice

When did you first become concerned?

Can your child:

Follow simple (check all that appply): ☐ Step Directions ☐ 2 Step Directions ☐ 3 Step Directions

Point to/go to/reach for/ or otherwise identify people and objects you name? ☐ Yes ☐ No

Point to basic body parts you name? ☐ Yes ☐ No

Answer simple yes/no questions accurately? ☐ Yes ☐ No

Answer simple "wh" questions accurately? (what, where, who, when, why, how) ☐ Yes ☐ No

COMMUNICATION CONTINUED

Which of the following describes how your child communicates: (check all that apply)

- ☐ Pointing
- ☐ Eye Contact
- ☐ Communication Boards
- ☐ Sign Language
- ☐ Communication Device (What Kind?)
- ☐ Symbols (gives Items symbols)
- ☐ Other (explain)
- ☐ Gesturing
- ☐ Facial Expressions
- ☐ Pulls Person
- ☐ Objects
- ☐ Pictures
- ☐ Writing
- ☐ Vocalizing
- ☐ Single Words
- ☐ 2 Word Phrases
- ☐ 3-4 Word Utterances
- ☐ Babbling
- ☐ Full Sentences

Please provide further explanations for any of the checked Items above:

Does your child communicate (verbally or non-verbally) to: (check all that apply)

- ☐ Ask for Wants/Needs
- ☐ Greet People
- ☐ Label People, Things, or Objects Around Them
- ☐ Ask Questions
- ☐ Ask for Help
- ☐ Get your Attention
- ☐ Share Information

INTELIGIBILITY

If your child speaks:

Do you have difficulty understanding his/her speech? ☐ Yes ☐ No ☐ Sometimes

How much of what he/she says do you understand? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%

Do others have difficulties understanding his/her speech? ☐ Yes ☐ No ☐ Sometimes

How much of what he/she says do you think others understand? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%

What does your child do when they are not understood? Please explain. (repeats or modifies message, gives up, becomes aggressive, etc.)

GOALS

What do you hope to gain from this evaluation?

What do you hope to get out of speech therapy treatments? What goals do you have?

Patient or Legal Guardian Signature **Date:**