

Talking Point Speech Therapy, LLC

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: _____

Father's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Father's Occupation: _____

Employer: _____

EMAIL Address: _____

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)

What are your concerns about your child's communication?

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