

# PATIENT INFORMATION

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Zip:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **School:** \_\_\_\_\_

**Parent/Caregiver's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Phone:** (mobile) \_\_\_\_\_ (work) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Parent/Caregiver's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Phone:** (mobile) \_\_\_\_\_ (work) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Other Children/Adults in Home:**

Name	Age	Relationship

**Primary home language:** \_\_\_\_\_

**Other languages spoken in home:** \_\_\_\_\_

**Reason for referral / Primary concern:** \_\_\_\_\_

**How did you find us?** \_\_\_\_\_ **Physician/Referral Name:** \_\_\_\_\_

**Person responsible for payment:** \_\_\_\_\_

# HEALTH HISTORY

Person Completing History: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Prenatal and Birth History**

During this pregnancy and/or delivery, did mother or baby experience any complications? If so, please describe. \_\_\_\_\_  
 \_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Has your child ever been hospitalized? Yes No *If yes, when and describe:* \_\_\_\_\_  
 \_\_\_\_\_

Has your child had any other significant illnesses, injuries, or surgeries? *If yes, when and describe:*  
 \_\_\_\_\_  
 \_\_\_\_\_

Child's current medications: \_\_\_\_\_

Please list any specific food, medicinal, or environmental allergies: \_\_\_\_\_

Illness	Age	Severity	Developmental Changes
Pneumonia			
Influenza			
Asthma			
Encephalitis			
Meningitis			
Whooping Cough			
Allergies			
High Fever (104+)			
Ear infections			
Seizures			
COVID-19			

**Prior Evaluations**

	<u>Date</u>	<u>Results</u>
Speech/Language	_____	_____
Occupational Therapy	_____	_____
Physical Therapy	_____	_____
Hearing	_____	_____
Vision	_____	_____
Neurological	_____	_____
Psychological	_____	_____
Other	_____	_____

*Please provide previous evaluation reports from other professionals or provide facility and/or name of evaluator to request records. This information may be helpful in assessing and planning of treatment for your child.*

Is there any additional information that will help us to better understand your child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DEVELOPMENTAL HISTORY**

**Early Development**

At what age did your child begin drinking from a cup? \_\_\_\_\_

At what age did your child begin eating table foods? \_\_\_\_\_

Does he/she drool? \_\_\_\_\_

Are there any previous or current feeding concerns/problems? Please explain:

\_\_\_\_\_  
\_\_\_\_\_

When did your child walk unaided? \_\_\_\_\_

Has there been any atypical motor development? \_\_\_\_\_

*Please continue onto Page 4 for additional information.*

## Speech and Language Development

During the first year, other than crying, would you describe your baby as: (check one)

silent baby

quiet baby

average noisy baby

very noisy baby

Describe your child's first vocalizations/sounds: \_\_\_\_\_

At what age did your child say his/her first words? \_\_\_\_\_

Examples of first words: \_\_\_\_\_

At what age could he/she name most familiar objects? \_\_\_\_\_

At what age did your child first begin to use two word combinations? (i.e. "want cookie") \_\_\_\_\_

Examples of two word combinations used: \_\_\_\_\_

At what age did he/she use complete sentences? (i.e.: "I go outside.") \_\_\_\_\_

Examples of complete sentences used: \_\_\_\_\_

Did speech learning ever seem to stop, regress, or change for a period? If yes, explain:

How intelligible is your child's speech to you? (Choose one)

How intelligible is your child's speech to others? (Choose one)

How does your child ask for what they want?

Does your child give up easily or become easily frustrated when trying to communicate? If yes, explain:

Does your child seem to have difficulty understanding speech?      Yes      No

Does your child have difficulty following directions?      Yes      No

## School and Social History

Current school/daycare your child attends: \_\_\_\_\_ Current grade: \_\_\_\_\_

