McLaren Lapeer Region
LAPEER, MI 48446
Speech Therapy Child History Form

This form must be completed prior to the patient's evaluation. Please fill out the information as accurately as possible. This information is confidential.

General Information:

Name:____ Today's date:_____/_____/_____

Date of Birth:_____/_____/_____ Age:_______ Gender:_____________________

Parent(s)/legal guardian: __________________________________ Phone: (_____)________-_________

__________________________________ Phone: (_____)________-_________

Referring Physician: __________________________________ Phone: (_____)________-_________

Primary Care Physician: __________________________________ Phone: (_____)________-_________

Patient History:

Describe your concerns with your child's speech, language, or feeding (*Please include any diagnosis that is relevant to the speech concerns you have for you child):*

____

____

____

When was the problem first noticed? ____

Is your child aware of the problem: □ Yes □ No

How does your child react to the problem? _______________________________________

Does your child interact/play with other children: □ Yes □ No

Do family members have difficulty understanding your child? □ Yes □ No

Do strangers have difficulty understanding your child? □ Yes □ No

What means does your child typically use to communicate: □ Words □ Gesture □ Point □ Other:_____________

Has your child ever failed a hearing screening/test?: □ Yes □ No

Family Information:

Please list all siblings:

Name	Age	History of Speech Deficits

Pregnancy and Birth History:

Did the mother experience any complications during pregnancy? □ Yes □ No

Explain:____

Type of Delivery:__________________________ Length of pregnancy:_____________(weeks)

McLaren-Lapeer Region
LAPEER, MI 48446
Speech Therapy Child History Form

(Pregnancy and Birth History Cont')
Were any medications/alcohol/drugs used during pregnancy? ☐ Yes ☐ No
Please list:____

Were there any complications with delivery? ____

Birth weight: ______________ Height:__________________

Were any of the following problems indicated immediately following birth or during the first 2 weeks of life? Please mark all that apply

- ☐ Jaundice
- ☐ Seizures
- ☐ Infection
- ☐ Medications
- ☐ Reflux
- ☐ Apnea
- ☐ Difficulty breathing
- ☐ Head injury
- ☐ Low muscle tone
- ☐ Feeding difficulties
- ☐ Intracranial bleeding
- ☐ Iv Fluids
- ☐ Surgery (please explain)
- ☐ Incubator
- ☐ Transfusions

Developmental History:
Please provide an approximate age at which your child accomplished the following:

Rolled over: __________________
Crawled: __________________
Walked Unassisted: ____________
First word: _________________________
Used 2 words together: ________________
Potty trained: ________________________

Feeding Development/History:
Does your child cough or choke while eating/drinking?: ☐ Yes ☐ No
If yes, how often?____
With what types of consistencies? (liquids, solids, sticky foods, pureed)________________________

Does your child drool? : ☐ Yes ☐ No

How does your child take in liquid? (*check all that apply*)

- ☐ Bottle
- ☐ Sippy Cup
- ☐ Cup
- ☐ Breast
- ☐ Straw

Medical History:

	YES	NO		YES	NO
Asthma			Ear Infections		
Allergies			Seizures		
Tonsillectomy			Adenoidectomy		
Cleft Lip/Palate			Chronic Colds		
Draining Ear (Tubes)			Convulsions		
Head Injury			Reflux		

Educational Information/ Past Therapy Information:

Name of your child's school:____________________________________Grade:________________________

What therapy services has your child previously received? : ☐ Speech ☐ Occupational ☐ Physical ☐ None
How often?____ Where?_______________________

List the goals that you would like your child to accomplish with speech therapy:
____
____