

**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: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

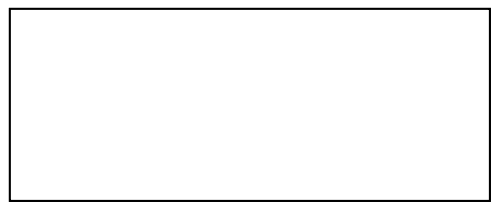
**Pregnancy and Birth History:**

Did the mother experience any complications during pregnancy?  Yes  No

Explain: \_\_\_\_\_

Type of Delivery: \_\_\_\_\_

Length of pregnancy: \_\_\_\_\_ (weeks)



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**(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*

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Jaundice    | <input type="checkbox"/> Apnea                | <input type="checkbox"/> Intracranial bleeding    |
| <input type="checkbox"/> Seizures    | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Iv Fluids                |
| <input type="checkbox"/> Infection   | <input type="checkbox"/> Head injury          | <input type="checkbox"/> Surgery (please explain) |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Low muscle tone      | <input type="checkbox"/> Incubator                |
| <input type="checkbox"/> Reflux      | <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Transfusions             |

**Developmental History:**

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

Rolled over: \_\_\_\_\_ First word: \_\_\_\_\_

Crawled: \_\_\_\_\_ Used 2 words together: \_\_\_\_\_

Walked Unassisted: \_\_\_\_\_ 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)*

- |                                    |                                 |
|------------------------------------|---------------------------------|
| <input type="checkbox"/> Bottle    | <input type="checkbox"/> Breast |
| <input type="checkbox"/> Sippy Cup | <input type="checkbox"/> Straw  |
| <input type="checkbox"/> Cup       |                                 |

**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:

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