REACH FOR SPEECH
& BEYOND, LLC

Patient History – Child

Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____

Person Completing This Form: _____

Relationship to Client: _____

Parent(s)/Guardian Name(s): _____

_____

Cell Phone: _____

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, myofunctional or hearing issues? ☐ Yes ☐ No

If yes, please describe: _____

Who referred you to Reach for Speech & Beyond? _____

Contact Info: _____

_____

Child's pediatrician: _____

_____

Pediatrician Mailing Address: _____

_____

_____

Pediatrician Email Address: _____

Pediatrician Telephone #: _____

Other doctor(s) or therapist(s) treating this child & contact info: _____

_____

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 _____

Do you give permission for us to contact any of the above listed professionals? ☐ Yes ☐ No

If yes, please provide name or write "all."

_____

What are your concerns?

_____

_____

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/high blood pressure, X-ray treatments, RH negative, Rubella/German measles, other illnesses, drugs or medications)?

☐ 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, torticollis)? ☐ Yes ☐ No

If yes, please describe: _____

Type of Feeding: ☐ Breastfed ☐ Bottle fed

DEVELOPMENTAL HISTORY

In early childhood, did the child have any feeding problems (such as poor control of sucking, food allergies, digestive upsets, refusal of certain foods/textures, etc.)? ☐ 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

Does the child have a history of thumb/finger/tongue sucking? Bite nails? ☐ 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

Do you notice your child hyperextending his/her neck/head? ☐ 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, ringing ears, evidence of hearing loss)?
☐ Yes ☐ No

If yes, please describe: _____

Has hearing been tested by an audiologist? ☐ 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 or Daycare _____

Address _____

City _____ State _____ Zip _____

Grade _____ Teacher _____

Does the child like school? ☐ Yes ☐ No

Does the child like the teacher? ☐ Yes ☐ No

How is your child performing in school (please note strengths and weaknesses)?

_____

_____

_____

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? _____

What are his favorite toys, characters or activities at this time?

_____

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?

What does the child do well?

What does the child have trouble doing?

Does the child have difficulty concentrating?

When sleeping, do you hear "breathing" or snoring? ☐ Yes ☐ No

Does your child typically sleep through the night? ☐ Yes ☐ No

Does your child toss and turn and/or sleep in strange positions when sleeping? ☐ Yes ☐ No

Does your child wake up with wetness on pillow/drooling? ☐ Yes ☐ No

Does your child experience night terrors? ☐ Yes ☐ No

Does your child experience bedwetting/or getting up multiple times a night to urinate? ☐ Yes ☐ No

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 his/her 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/spontaneously (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 compared to their peers? ☐ Yes ☐ No

Does the child prefer to use speech or gestures, e.g. pointing, pulling, reaching etc. when communicating?

Do you have any further questions and/or comments?

_____ _____

Parent/Guardian Signature / Date Relationship to Patient