NW SPEECH THERAPY, LLC.
CONFIDENTIAL PERSONAL HISTORY RECORD

PERSONAL INFORMATION:
Child's Name: ______________________________ Birthdate: ___________ Sex: Male or Female
Primary Language used in the home:__________________

Mother's name: _____________________________________ Date of birth:_________
Home Address: ____________________________________Phone #: _____________

Father's name:______________________________________ Date of birth:_________
Home Address (if different): ____________________________________Phone #: _____________

How did you hear about us? _______________________________________

FAMILY HISTORY:
List other people in the child's home:

Name:	Age:	Relationship (bro, sis, half, etc.)
__________________________	___________	________________________________
__________________________	___________	________________________________
__________________________	___________	________________________________
__________________________	___________	________________________________

Please describe any family history of speech/language or hearing difficulties:
____
____

What is your child's general health? ____

Is your child receiving services through the school?____________Early Intervention?_______________

CONCERNS and EXPECTATIONS:

Describe what you perceive as your child's speech and/or language problem:_____________________
____
____

What if anything has been done about the problem prior to now:___________________________________
____

What would you like to see done about your child's speech and/or language problem:____________________
____
____

What are some of the questions that you would like answered about your child's problem:
____
____

SPEECH AND LANGUAGE DEVELOPMENT:

How much does someone unfamiliar to your child understand him/her_________ %
Is your child showing frustration at not being understood?__________
Does your child understand what you are saying?___________________
Does your child follow directions easily_____________
What sounds do you hear your child having difficulty with?________________________________

HEARING/AUDIOLOGY:
Is there a family history of hearing loss?___________
If yes, please explain:____
What concerns, if any, do you have regarding your child's hearing?______________________________
Has your child had his/her hearing tested?______ when?_______ results?________________________
Is your child sensitive to noises?_______________ which ones?________________________________

MEDICAL HISTORY:
Please describe any complications during your pregnancy or your child's birth: (use of alcohol/drugs, prematurity, infections, injuries, time spent in the NICU, etc.)
____
____
____

Has your child ever been diagnosed as having any of the following disorders or problems:
Respiratory Infections:_____
Tonsils/adenoids removed?:_____
Asthma:_____
Vision Problems:_____
Head Injury:______
Colds: _____
Bronchitis:_____
Heart Problems:_____
Seizures: _____
Surgeries:_________
Ear Infections: _____ Tubes placed?:________when?:________________________________
Allergies: _____if YES, please list food allergies or otherwise___________________________
Hospitalizations (explain):____
Emergency room visits (explain):____

Autism/PDD NOS:_____
Emotional/Behavioral disorders:_____
Cleft lip/palate_____
Learning disabilities:_____
Dyslexia_____
Hearing Impairment:____
Genetic Syndrome:_____ (please specify): ____

Are your child's shots/immunizations up to date? ___________

MEDICATIONS: Does your child take any medications? Please list: __________________________________
____

NUTRITION/ FEEDING:
Please describe any eating difficulties the child has, or had (ie. Sucking, chewing, swallowing, choking/gagging, losing liquids through nose, stuffing mouth, etc) as well as any other concerns:
____
____
____

Are there any foods that your child refuses to eat?____

Has your child ever seen a dentist/orthodontist?______________
Has that dentist/orthodontist diagnosed your child with any dental anomalies (ie. Underbite, overbite, tongue thrust, etc)____
Did your child use a pacifier?_______digit/thumbsuck?_______when did they stop?______________
Does your child (currently) mouth non-edible objects? (ie. rocks, dirt, toys, sleeves)_______________________
Does your child allow toothbrushing?____

MOTOR DEVELOPMENT:

Check all that apply to your child's motor skills:
Seems weaker than others his/her age (tires easily)______
Difficulty with hopping, skipping, running, jumping compared to others his/her age______
Clumsy, bumps into things, falls a lot_____

Does your child have **DIFFICULTY** with the following tasks?
Drawing/coloring/cutting?_____
Fasteners (buttons/zippers)?______
Handwriting?____
Using two hands together?_____

SENSORY:
Is/does your child:
Dislike being bathed or having his/her hands, face, hair washed?_________
Overly active and hard to calm?__________
Able to pay attention and play with toys for reasonable time for age?________
Restless and fidgety during times when quiet concentration is required?________
Prefer certain clothing and complains about tags in clothing?_________
Over-react or under-react to physically painful experiences?________
Like movement experiences?_________
Falls down often and has difficulty with balance?________
Difficult to take on outings (grocery store, friends house)?_______
Afraid or over/under-reacts to noises/sounds?_______

Thank you for your time! Please bring this form to the scheduled evaluation.