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 #: _____

Insurance: _____ID#:_____Group #_____
Provider or Customer Care #:_____
Primary Care Physician:_____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 difficulties:
_____
_____

SPEECH AND LANGUAGE DEVELOPMENT:
(approximate age when your child accomplished these milestones):

First Words:_____
Used simple sentences:_____
How much of your child's speech do you understand_____%
How much does someone unfamiliar to your child understand him/her_____ %
Is your child showing frustration at not being understood?_____
Does your child repeat sounds, words or phrases over and over?_____

Does your child initiate play with others or play alone?_____
Are your child's difficulties impacting his school/social interactions?_____
How would you describe your child's personality? (shy, overachiever, class clown, perfectionist?, etc)_____

Does your child understand what you are saying?_____
Does your child retrieve/point to common objects upon request (ball, cup, shoe)?_____
Does your child follow simple directions ("shut the door" or "get your shoes")?_____
Does your child respond correctly to yes/no questions?_____
Does your child respond correctly to who/what/where/when/why questions?_____

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:_____ Colds: _____
Tonsils/adenoids removed?:_____ Bronchitis:_____
Asthma:_____ Heart Problems:_____
Vision Problems:_____ Seizures: _____
Head Injury:_____ Surgeries:_____
Ear Infections: _____ Tubes placed?:_____when?:_____
Allergies: _____if YES, please list food allergies or otherwise_____
Hospitalizations (explain):_____
Emergency room visits (explain):_____

Autism/PDD NOS:_____ Learning disabilities:_____
Emotional/Behavioral disorders:_____ Dyslexia_____
Cleft lip/palate_____ 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?_____
What are his favorite foods?_____

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)_____
Does your child use a pacifier?_____digit/thumbsuck?_____when did they stop?_____
Does your child (currently) mouth non-edible objects? (ie. rocks, dirt, toys)_____
Does your child allow toothbrushing?_____

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.