

**NW SPEECH THERAPY, LLC.**  
**CONFIDENTIAL PERSONAL HISTORY RECORD**

**PERSONAL INFORMATION:**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: Male or Female  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Primary Language used in the home: \_\_\_\_\_

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Mother's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Home Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Social Security #: \_\_\_\_\_

Father's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Home Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Social Security #: \_\_\_\_\_

Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**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:**

(specify age when your child accomplished these milestones):

Babbled: \_\_\_\_\_

First Words: \_\_\_\_\_

Put two words together (ex. hi daddy, mommy go) \_\_\_\_\_

Used simple sentences: \_\_\_\_\_

How many words can your child say? (list if fewer than fifteen) \_\_\_\_\_  
\_\_\_\_\_

How long are your child's 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 use gestures (pointing) to make his needs know? \_\_\_\_\_

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.)

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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:

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**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:

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Does your child require assistance to eat? \_\_\_\_\_  
When did your child stop using a bottle? \_\_\_\_\_ a sippycup? \_\_\_\_\_  
Are there any foods that your child refuses to eat? \_\_\_\_\_  
What are his favorite foods? \_\_\_\_\_  
What type of cup (sippy, open, straw) does your child drink out of (list all): \_\_\_\_\_

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/thumb-suck? \_\_\_\_\_ when did they stop? \_\_\_\_\_  
Does your child (currently) mouth non-edible objects? (ie. rocks, dirt, toys) \_\_\_\_\_  
Does your child allow toothbrushing? \_\_\_\_\_

**MOTOR DEVELOPMENT:**

specify age when your child accomplished these milestones:

Rolled over: \_\_\_\_\_

Crawled: \_\_\_\_\_

Walked alone: \_\_\_\_\_

Sat alone: \_\_\_\_\_

Pulled to Stand: \_\_\_\_\_

Dressed self: \_\_\_\_\_

**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!