The Physical Therapy Specialty Center

a division of **Primary Care Partners**
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"Our Head, Hearts and Hands Helping You to Better Health"

PATIENT HISTORY FORM – Speech - Pediatric PLEASE PRINT

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Child's Name: _____ Date of Birth: _____

Parent/Guardian Names: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Child lives with both parents? Yes_____ No_____ If no, with whom does the child live? _____

Primary Language spoken in home: _____ Secondary Language: _____

Pediatrician: _____ Pediatrician Phone: _____

Referring Physician: _____ How did you hear about us? _____

Previous speech therapy evaluations (list): _____

Other therapies to date (list): _____

Describe present problem:

_____

CURRENT GENERAL HEALTH

**Has your child had any earaches/ear infections? Yes_____ No_____ Eustachian tubes? _____

If chronic, please explain frequency here:

_____

Allergies? Yes_____ No_____ If yes, describe: _____

Any other serious or recurrent illness? _____

Any operations? Yes_____ No_____ If yes, please describe_____

_____

Any accidents/falls involving trauma to the head? _____

Vision problems: Yes_____ No_____ If yes, Past_____ Current_____ Please describe_____

Hearing difficulties: Yes_____ No_____ Dental problems: Yes_____ No_____ If yes, please describe_____

_____

Other Medical History not listed above:_____

PRENATAL/BIRTH HISTORY

Full Term? Yes_____ No_____ If no, how many weeks?_____ Birth Hospital:_____ State:_____

Illnesses or accidents during pregnancy:_____

Use of alcohol, tobacco or medications during pregnancy: _____

Birth Weight: _____ Delivery: Vaginal_____ Cesarean_____ N.I.C.U. – Yes _____ No _____

Breech (Feet First) _____ Head First _____ Respiratory Issues at birth: _____

Other unusual conditions that may have affected pregnancy/birth? _____

MEDICAL HISTORY

Please check if your child has had any of the following (and if so, at what age):

Seizures_____ High fevers_____ Chicken pox_____ Whooping cough/Diptheria_____ Croup_____ Pneumonia_____

Tonsillitis_____ Meningitis_____ Encephalitis_____ Rheumatic Fever_____ Tuberculosis_____ Sinusitis_____

Chronic colds_____ Enlarged glands_____ Thyroid_____ Asthma_____ Heart trouble_____

Explained any checked items here: _____

_____

Are immunizations current? Yes_____ No_____ Have you traveled outside the U.S. within the past 60 days? _____

If so, where? _____

DEVELOPMENTAL HISTORY

Age when child: (may indicate if it occurred at the expected time or delayed)

Sat up alone_____ Crawled_____ Walked_____ Toilet trained_____ Dressed independently_____ Tied shoes_____

Is the child left or right handed? _____

LANGUAGE DEVELOPMENT

Age when your child spoke first word: _____ combined words: _____ spoke in sentences: _____

What was your child's first word(s)? _____

First Sentence? _____

Which sounds (if any) are of concern? _____ How many words can your child say? _____

List if fewer than fifteen: _____

How many words are your child's sentences? _____ Does your child have difficulty understanding you? Yes_____ No_____

If yes, please describe: _____

Does your child have difficulty following directions? _____ Describe: _____

Any speech/hearing problems in the immediate or extended family (explain)? _____

SOCIAL DEVELOPMENT

Name and ages of siblings: _____

How many minutes/hours of television does your child watch per day? _____ Electronics? _____

What motivates your child most? _____

What discipline methods work best? _____

SCHOOL HISTORY

Child's Current School: _____ Grade: _____

Child's performance educationally: _____

Receiving special services at school? Yes_____ No_____ If yes, what services? _____

Does your child currently have an IFSP or IEP? _____

How does your child's teacher describe his/her performance? _____

Has the teacher expressed any concern? Yes_____ No_____ If yes, please describe: _____

_____

AUTHORIZATION FOR MEDICAL TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I consent to physical therapy treatment/provisions of modalities and procedures, as indicated by the therapist and/or physician; which includes Telehealth options. I have reviewed and agree with all office policies including Attendance and Patient Rights and Responsibilities.

PATIENTS SIGNATURE: _____ DATE: _____

GUARDIAN'S SIGNATURE (if patient is under 18): _____