Texoma Pediatric Therapy Services, LLC

Laurie Nix, M.Ed., CCC/SLP

514 N. Elm Street

Sherman, Texas 75020

Tel (903) 436-4300 | *Fax* (903) 868-2330

www.texomaspeechtherapy.com

Patient History

Name: ____

Date of Birth: _____ / _____ / _______ Age: _____ Sex: ☐ M ☐ F

Address: ____

City: ______________________ State: _________ ZIP: __________

Telephone: ______________________________

Person Completing this Form: ______________________________

Relationship to Patient: ______________________________

Mother's Name: ______________________________ Age: _________

Address: ____

City: ______________________ State: _______ ZIP: _________

Mother's Occupation: ______________________________

Mother's Employer: ______________________________

Mother's Completed Level of Education: ______________________________

Father's Name: ______________________________ Age: __________

Address: ____

City: ______________________ State: _________ ZIP: _________

Father's Occupation: ______________________________

Father's Employer: ______________________________

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Father's Completed Level of Education: ______________________________

List all children in the family from oldest to youngest:

Name	Age	Sex	Grade in School	General Health

Does anyone in your family, apart from the patient, have speech- and/or language-related difficulties? ☐ Yes ☐ No

If yes, please describe *(cont'd. on next page):*

____

____

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Who referred you for this evaluation? ______________________________

Child's pediatrician or family doctor ______________________________

Address ____

Other doctor(s), if any, who are also treating the patient

____

____

____

Has the patient had any previous testing and/or therapy for speech- and/or language-related problems? ☐ Yes ☐ No

If yes, name the agency and the date(s) the testing and/or therapy took place:
(Please request that copies of any and all test results be sent to our office.)

____

____

Why are you bringing your child to see us today? *(cont'd. on next page.)*

____

____

____

BIRTH HISTORY

Child's Weight at Birth ______________________ Was the child born at full term? ☐ Yes ☐ No

Were there any unusual factors relating to the pregnancy (i.e. – toxaemia, X-ray treatments, RH negative, German measles, other illnesses, drugs and/or medications, previous miscarriages)?

☐ Yes ☐ No

If yes, please describe:

____

____

____

Type of birth: ☐ Normal ☐ Induced ☐ Forceps ☐ Caesarian ☐ Premature: number of weeks __________

Were there any physical deformities or malfunctions observed at birth (i.e. – "blueness," jaundice, abnormal head shape)? ☐ Yes ☐ No

If yes, please describe:

____

____

DEVELOPMENAL HISTORY

In early childhood, did your child have any feeding problems (e.g. – poor control of sucking, food allergies, and/or digestive upsets)? ☐ Yes ☐ No
If yes, please describe:

____

____

Ages your child developed the following behaviors:

Sitting unsupported: ______
Walking: _______
Eating solid foods: ______
Self-feeding: ________
Crawling: _________
Self-dressing: _________
Standing alone: ________
Bladder/bowel control: __________

Do you feel that your child was late or had difficulty in the development of any or all of the above behaviors?
☐ Yes ☐ No

MEDICAL HISTORY

Date and type of last medical examination: ___________________________________

List ages for any of the following childhood diseases:

Whooping cough _______
Pneumonia ________

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Mumps _______ Chicken Pox _________

Measles ________ Tonsillitis _________

Rheumatic Fever _________ Other: ____

Where there any complications with any of the above, such as high/persistent fevers, convulsions, and/or persistent muscle weakness? ☐ Yes ☐ No

If yes, please explain:

____

____

____

Is your child subject to frequent colds and/or sore throats? ☐ Yes ☐ No

Has your child had allergies, hay fever, etc.? ☐ Yes ☐ No

If yes, please list: ____

Does your child tend to breathe with his/her mouth open? ☐ Yes ☐ No

Had your child had any medical operations? ☐ Yes ☐ No

If yes, please describe: ____

Has your child had their tonsils and/or adenoids removed? *(Circle one, if any.)*

If yes, at what age? ____________________

If there were any complications, please describe:

____

____

Has your child's hearing been tested? ☐ Yes ☐ No

If yes, list most recent test date: ______ / ________ / __________

Results: ____

Has your child ever had ear (PE) tubes inserted? ☐ Yes ☐ No

If yes, when? _________________

List any complicatons:

____

____

Does you child have any dental problems? ☐ Yes ☐ No

If yes, please describe:

____

____

____

Has your child previously seen a specialist for any reason? ☐ Yes ☐ No

If yes, please explain:

____

____

____

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EDUCATION HISTORY

Current School ____

Address ____

City ____ State _______ ZIP ____________

Current Grade _____ Teacher(s) ____

Did your child attend nursery school? ☐ Yes ☐ No

If yes, from age _________ to age ____________

At what age did you child attend kingergarten? ____________________________________

Does your child currently like school? ☐ Yes ☐ No

Describe your child's performance in school *(please be sure to note strong and weak areas):*

____

____

____

Does your chlid attend any special classes (e.g. – speech therapy, language development, reading, resource room, special education, et al)? ☐ Yes ☐ No

If yes, please describe:

____

____

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DAILY BEHAVIOR

Where does your child usually play? ______________________________

Are there children close to your child's age in your neighborhood? ☐ Yes ☐ No

Does your child prefer to play alone? ☐ Yes ☐ No

Does you child prefer to play with older or younger children? *(please circle one, if any.)*

Does your child have a close friend? ☐ Yes ☐ No

What are your most frequent discipline problems with your child?

____

____

____

Who does the disciplining? ______________________________

How do you enforce discipline? ______________________________

How do you reward good behavior?

____

____

What does your child do well?

____

____

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What does your child have struggles with?

____

____

Does your child have difficulty concentrating?

____

____

COMMUNICATION HISTORY

Is your child's speech understandable to *(check all that apply):* ☐You ☐Friends ☐Strangers ☐Extended Family

List sounds or words that your child has difficulty pronouncing:

____

____

How does your child compare with his/her siblings in regard to speech development?

____

____

Does your child use words in meaningful ways for his/her age? ☐ Yes ☐ No

Give examples of sentences your child uses by himself/herself (NOT sentences that are repeated after you):

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____

____

____

Age your child begin babbling? _________ Age first words were said? _______

Age two words were put together? _________ Age three-word sentences started being used? ___________

Does your child seem to understand directions? ☐ Yes ☐ No

Does your child prefer to use speech or gestures when communicating?

____

____

Do you have any questions?

____

____

Parent/Guardien Signature: ____

Relationship to Patient: ____

Date this Form was Signed: ______ / _______ / __________