Speech Therapy Plus, pllc.
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Pediatric and Adolescent Patient Medical History Form

List members of Immediate Family Currently Living in the Home

Name Age Relationship Health Problems

_____
_____
_____
_____
_____

Prenatal/Birth History: (Write on the back if needed)

Were there any complications with the pregnancy? Yes ____ No ____ If yes, please explain:

_____

Were there any complications with the delivery: Yes ____ No ____ If yes, please explain:

_____

Birth Weight _____

Were there any serious medical conditions following the birth? Yes _____ No ____

If yes, please explain: _____

_____

Medical History:

Please indicate if your child has experienced any of the following conditions:

Allergies Yes _____ Explain_____
Attention Deficit Disorder Yes _____ Explain_____
Autism Yes _____ Explain_____
Asthma Yes _____ Explain_____
Concussion Yes _____ Explain_____
Epilepsy Yes _____ Explain_____
High Fevers Yes _____ Explain_____
Intellectual Disability Yes _____ Explain_____
Learning Disability Yes _____ Explain_____
Meningitis Yes _____ Explain_____
Muscular Disease Yes _____ Explain_____
Seizures Yes _____ Explain_____
Traumatic Brain Injury Yes _____ Explain_____
Vision Problems Yes _____ Explain_____
Other_____

If your child has had other significant medical treatment, please explain:

_____

Has your child ever been under the care of any other specialists? If yes, please list the doctor and state the dates treated:

___ Neurologist: _____

___ Psychologist: _____

___ Ear, Nose and Throat: _____

___ Developmental Pediatrician: _____

___ Other: _____

Would you like a copy of your child's report sent to them in addition to the pediatrician? Yes ____ No ____

If not, please explain: _____

Are your child's immunizations up to date? Yes ____ No ____

Please list all medications your child is currently taking: _____

Is your child allergic to any medications? YES ____ **NO** ____

If yes, please list medications and their reactions: _____

Does your child have any food allergies? YES ____ **NO** ____

If yes, please list all allergies: _____

Does your child currently have any medical problems? Yes ____ No ____

If yes, please explain: _____

How many ear infections does your child have per year? _____

Has your child had ear tubes? Yes ____ When _____ No ____

Has your child's hearing ever been tested? Yes ____ No ____

If yes, what were the results of that testing: _____

Does he/she wear a hearing aid? Yes ____ No ____ If yes, for how long? _____

Have your child's eyes been examined? Yes ____ No ____ If Yes, when & what were the results of that examination:

_____

Is your child currently wearing glasses? Yes ____ No ____

Please list any major illnesses, injuries or operations on the child. Include information such as type, age, treatment, complications and any continuing effects associated with these events: _____

Family History:

If patient or family member has or has had any of the following problems, mark as indicated below and explain in the space provided:

P-Patient M-Mother F-Father GM-Grandmother GF-Grandfather A-Aunt U-Uncle

___ chronic illness: _____

___ allergies: _____

___ speech problem: _____

___ hearing problem: _____

___ swallowing problems: _____

___ asthma/lung problems: _____

___ respiratory infections: _____

___ tuberculosis: _____

___ immunity problems/HIV: _____

___ heart condition: _____

___ cerebral palsy: _____
___ intellectual disability: _____
___ down syndrome: _____
___ autism: _____
___ cancer: _____
___ seizures: _____
___ mental illness: _____
___ other: _____

Developmental History:

Are there or have there been any developmental issues with the child? Yes ____ No ____

_____

Did your child's speech/language seem to develop normally? Yes ____ No ____

_____

At what age was a speech problem first noticed? _____

Do you consider this problem: Severe ____ Moderate ____ Mild ____

Do family members understand your child's speech? Always ___ Sometimes ____ Very little ____

Do people not familiar with your child understand their speech? Always ____ Sometimes _____ Very little ____

Does your child stutter or stammer? Yes ____ No ____ If yes, for how long? _____

Are there any concerns regarding your child's voice in relation to his/her peers? (for example: very loud, hoarse, very soft, nasal?)
If yes, please explain: _____

Receptive and Expressive Language Skills

Please answer "yes" or "no" or "sometimes" to the following questions:

Does your child respond to his/her name? Yes _____ No _____ Sometimes _____

Will your child get familiar objects when asked? Yes _____ No _____ Sometimes _____

Does your child follow simple directions? Yes _____ No _____ Sometimes _____

Will your child point to pictures as you name them? Yes _____ No _____ Sometimes _____

Does your child name pictures? Yes _____ No _____ Sometimes _____

Does your child ask questions? Yes _____ No _____ Sometimes _____ (Please give examples)

_____

Does your child repeat or "echo" others' expressions? Yes _____ No _____ Sometimes _____

Does your child repeat questions or parts of questions rather than answering them? Yes _____ No _____ Sometimes _____

Does your child **excessively** recite/repeat phrases from movies, songs or television programs? Yes _____ No _____
Sometimes _____

Does your child fixate on the same subject day after day? Yes ___ No ___ Explain _____

Has your child said a word a few times, then never used it again? Yes _____ No _____ Sometimes _____

IF "yes", when? _____ What words? _____

Did language development seem to just stop? Yes _____ No _____ Sometimes _____

IF "yes", when? _____

How does your child indicate his/her needs/wants to you?

_____

How does your child indicate he/she does **NOT** want something or does not want to do something?

_____

Motor Milestones

Please indicate the age or approximate age at which the following occurred:

Cooing _____ Babbling _____ Crawled _____ Sat alone _____ Walked unaided _____

Fed self _____First words _____Dressed self _____Toilet trained _____

Expressive Vocabulary of approximately 50 words: _____

Two-word combinations _____ *(Examples: more milk, me do, me down)*

Short Sentences _____ *(Examples: Me want cookie. Me do it.)*

Behavioral Information

General

Is withdrawn: Yes _____ No _____ Sometimes _____

Rocks back and forth? Yes _____ No _____ Sometimes _____

Covers ears with hands? Yes _____ No _____ Sometimes _____

Has limited eye contact? Yes _____ No _____ Sometimes _____

Has difficulty with change/transitions? Yes _____ No _____ Sometimes _____

Other comments _____

_____

Play

Prefers to play alone? Yes _____ No _____ Sometimes _____

Plays poorly with other children or does not interact with others? Yes _____ No _____ Sometimes _____

Frequently lines items in a row? Yes _____ No _____ Sometimes _____

Holds (clutches) items for extended periods of time? Yes _____ No _____ Sometimes _____

Frequently counts (objects, items, actions etc.) Yes _____ No _____ Sometimes _____

Has unusual interest (strips of paper, electrical cords etc.)? Yes _____ No _____ Sometimes _____

Other comments _____

_____

Conduct

Displays temper tantrums? Yes _____ No _____ Sometimes _____

Consistently has a catastrophic reaction when told “no”? Yes _____ No _____ Sometimes _____

Discipline is ineffective? Yes _____ No _____ Sometimes _____

Is overly active? Yes _____ No _____ Sometimes _____

Has a short attention span? Yes _____ No _____ Sometimes _____

Is aggressive towards self? Yes _____ No _____ Sometimes _____

Is aggressive towards others? Yes _____ No _____ Sometimes _____

Is destructive with objects? Yes _____ No _____ Sometimes _____

Other comments _____

Are you concerned about your child’s feeding / swallowing skills? Yes _____ No _____ If yes, please explain:

_____

Does your child stuff food in his/her mouth? Yes _____ No _____

Is your child a pick eater? Yes _____ No _____ If yes, please explain:

_____

Home Information:

Does the child live in the home with both parents? ___ Yes ___ No

If no, who does the child live with? _____

Is the child adopted? ___ Yes ___ No? If yes, how old were they? _____

What is the primary language spoken in the home? _____

If there is more than one language spoken, please list other languages spoken: _____

School Information:

Is the child currently in daycare? ___ Yes ___ No If yes, how many days per week & where _____

Does your child attend pre-school? ___ Yes ___ No If yes, how many days per week & where _____

Has your child previously received or currently receiving speech services from ECI? ___ Yes ___ No

If yes, at what age and for how long? _____

If your child is school-aged, what is their current grade level? _____

What school/district does your child attend? _____

Does your child receive speech services at his/her school? ___ Yes ___ No

How would you describe your child's grades? _____

Has your child repeated a grade level(s)? ___ Yes ___ No If yes, please explain: _____

Are there any concerns about your child's school experience that you would like to inform me of at this time?

_____

Does your child have specific things that he/she really likes/dislikes? _____

What is your primary goal for your child to achieve through speech therapy services? _____

_____

Is there anything else you would like for me to know about your child (things that upset him, things he will work for, etc.)?

_____

What is the best time for your child to be seen? _____

Do you prefer a set schedule or flexible schedule? _____

Re-Eval Update Review
(Initial only when office requests)

_____	_____
Initials	**Date**
_____	_____
Initials	**Date**
_____	_____
Initials	**Date**
_____	_____
Initials	**Date**