

**CHILD/ADOLESCENT (6-17 YEARS)**  
**SPEECH-LANGUAGE PATHOLOGY HISTORY FORM**

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

Person completing form: Patient Spouse Parent/Guardian Other-Name \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_  
 Referred by: \_\_\_\_\_  
 Reason for evaluation: \_\_\_\_\_  
 Insurance: \_\_\_\_\_ Referral Needed: yes no  
 Policy Number: \_\_\_\_\_

**Results will be sent to names/locations listed below if address or faxes are provided**

Name	Address or Fax	Phone

**Disclosure of healthcare information will only be provided is authorized by the patient or legal guardian except for known healthcare providers**

Name	Relationship to patient	Address	Phone	Fax

**I authorize the department to disclose healthcare information to names above. Valid for one year.**

Signature of  Patient Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
 Printed name of Parent/Guardian: \_\_\_\_\_

**Past Medical History**

- |                        |  |                      |  |
|------------------------|--|----------------------|--|
| ADD/ADHD               | <input type="checkbox"/> YES <input type="checkbox"/> NO | HIV Positive         | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| AIDS                   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Allergies            | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Laryngitis             | <input type="checkbox"/> YES <input type="checkbox"/> NO | Asthma               | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Learning Disability    | <input type="checkbox"/> YES <input type="checkbox"/> NO | Chicken Pox          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Mental Retardation     | <input type="checkbox"/> YES <input type="checkbox"/> NO | Cancer_____          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Physical Limitations   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Cerebral Palsy       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Pneumonia/Bronchitis   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Developmental Delays | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Respiratory Disease    | <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes             | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Shortness of breath    | <input type="checkbox"/> YES <input type="checkbox"/> NO | Ear Infections       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Seizures               | <input type="checkbox"/> YES <input type="checkbox"/> NO | Epilepsy             | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sinus Problems         | <input type="checkbox"/> YES <input type="checkbox"/> NO | Gastric Reflux       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Speech/Lang Impairment | <input type="checkbox"/> YES <input type="checkbox"/> NO | Head Injury          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hearing Loss           | <input type="checkbox"/> YES <input type="checkbox"/> NO | Swallowing Problems  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Problems         | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tracheostomy tube    | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Ventilator Dependency  | <input type="checkbox"/> YES <input type="checkbox"/> NO | High fevers          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Visual Impairment      | <input type="checkbox"/> YES <input type="checkbox"/> NO | Voice Impairment     | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Stroke                 | <input type="checkbox"/> YES <input type="checkbox"/> NO | Brain Tumor          | <input type="checkbox"/> YES <input type="checkbox"/> NO |

**Comments/Other Medical History:** \_\_\_\_\_  
 \_\_\_\_\_

**Speech Pathologist's notes:** \_\_\_\_\_  
 \_\_\_\_\_

Name: \_\_\_\_\_

Please list any surgeries/medications (and reason for medication): \_\_\_\_\_

Significant Family medical history: \_\_\_\_\_

Have you ever been examined or treated by the following?

		Name/Findings
Ear Nose and Throat Specialist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Eye Specialist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Neurologist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Psychiatrist/Psychologist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Speech/Language Pathologist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Neuropsychologist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Audiologist (Hearing Test)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Physical or Occupational Therapist	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

Does your child receive any current physical, occupational or speech therapy? NO YES (Explain): \_\_\_\_\_

**Educational History:** School name/Address/Phone: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_

Does your child have any difficulty communicating at school? \_\_\_\_\_

Please describe any special tutoring/therapy: \_\_\_\_\_

Does your child have difficulty with attention, learning, reading, spelling, writing, math? (circle and explain) \_\_\_\_\_

**Family and Social History:**

List any brother/sisters and ages? \_\_\_\_\_

Who lives in the home? \_\_\_\_\_

Marital status of parents? Married Separated Divorced Other

Patient Tobacco Use? YES NO Alcohol Intake? YES NO Substance Dependency? YES NO

If any yes responses, please explain: \_\_\_\_\_

**Activities:**

In school: \_\_\_\_\_

Outside of school: \_\_\_\_\_

**General Behaviors:**

Do you think your child gets along well with other children? YES No Adults? YES NO

Does your child exhibit any clumsiness, hitting, tantrums or other behavior that interferes with social interaction?

NO YES, explain: \_\_\_\_\_

**Please write down any other information that you feel would be important for us to know:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Speech Pathologist's notes:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Speech Pathologist: \_\_\_\_\_  
Signature ID # Date/Time