Spring Branch Speech Therapy
Pediatric Speech, Language, and Feeding Intervention

Patient Social and Medical History Form

Background Information:

Child's Full Name: _____

Date of Birth: _____

Home Address: _____

Best contact phone number: _____ E-mail Address: _____

Pediatrician's Name:_____ Phone: _____

Referring Physician (if applicable): _____ Phone: _____

Father's Name: _____ Date of Birth: _____

Occupation: _____ Highest Level of Education:_____

Relationship to Child (please circle one): Biological Adoptive Step Foster Other

Mother's Name: _____ Date of Birth: _____

Occupation:_____ Highest Level of Education: _____

Relationship to Child (please circle one): Biological Adoptive Step Foster Other

Status of Parent's Relationship (please circle one): Married Divorced Never Married Other

Persons living in the Child's Home: _____

_____

Family Concerns: Please describe your concerns regarding your child's speech, language, and feeding development.

_____

_____

_____

_____

_____

_____

Prenatal Information:

Did you have trouble getting pregnant? _____

Please circle if any of the following were used during pregnancy:

Prenatal Vitamins Alcohol Cigarettes Drugs (Pharmaceutical or Recreational)

Did you have any problems during your pregnancy? _____

Birth History:

My child was born at _____ weeks gestation, weighing ____ lbs and ____ oz

Delivery was… Vaginal Cesarean Section

Use of vacuum or forceps?

Were there any problems during delivery? _____

What were your child's APGAR scores? At 1 minute _____ 5 minutes_____

Were there any problems following birth? Please circle any and all that apply.

Turned blue	Had bruising
Required oxygen	Infections
Required resuscitation	Congenital birth defects
Considered small for their age	Aspiration (meconium or fluid)
Had tremors or seizures	Respiratory distress
Low tone	Choking or vomiting episodes
Brain hemorrhage	Tube feedings
Anemia or blood transfusions	Needed medications
Jaundice	

Length of stay in the hospital_____

Was your child fed by breast or bottle? _____

Formula or breast milk? _____ If formula, please specify _____

Any trouble feeding (spillage, reflux symptoms, choking, vomiting, or others)? _____

_____

Were there any problems during infancy? (please circle any/all that apply):

Frequent Colds/Respiratory Illness

Frequent Strep throat/Sore throat

Frequent Ear infections (PE Tubes?)

Colic

Reflux

Trouble sleeping

Drooling

Temper tantrums

Allergies or Asthma

Heart Condition

Anemia/blood disorder

Kidney/renal disorder

Urinary Problems

Skin disorder/problems (excema?)

Visual problems

Neurological disorder

Seizures

Stomach disorders/pain

Vomiting/digestion problems

Failure to gain weight/feeding problems

Constipation/diarrhea problems

Dehydration

Hearing loss

Significant accidents

Head injuries or concussions

Ingestion of toxins, poisins, foreign objects

Major medical procedures

Chronic medications (dosage and frequency)

Any major childhood illnesses (pox, croup, measles, mumps, meningitis, etc)

Please list any hospitalizations and/or surgeries, the reason for the surgery, and the dates of the procedures.

1. _____
2. _____
3. _____
4. _____

_____

Present Heath Information:

Most recent height: _____ Weight: _____ Date: _____

Current allergies and/or current medications: _____

Developmental History: Please list the ages at which your child met the following milestones.

Sat up without help _____
Crawled _____
Walked _____
Said their first word _____
Combined two words _____
Fed themselves _____
Gained bladder/bowel control _____
Dressed themselves _____

When did you first know your child was developing differently than his or her peers? _____
_____
_____

Do you feel your child demonstrates any trouble with fine motor skills (hand writing, fastening clothing, tying shoes), sensory concerns (dislikes loud noises, likes to spin or rock, dislikes being dirty), or physical difficulties (throwing a ball, riding a bike, running)? _____
_____

Has your child ever been evaluated for your speech, language, or feeding concerns? _____
_____
_____

Has your child ever attended speech, language, feeding, occupational, and/or physical therapy? _____
_____
_____

Do you have trouble understanding your child's pronunciation of words? _____
If yes, what percentage of your child's speech do you understand (50%, 75%, etc)? _____
People who are less familiar with your child or strangers (25%, 50%, etc)? _____

Does your child fit any of the following descriptions (please circle any/all that apply):

- Has trouble paying attention
- Has trouble sitting still
- Has difficulty seperating
- Aggressive behaviors
- Nervous Habits
- Mood Swings
- Performs repetitive behaviors (spinning, hand flapping, jumping, etc)
- Prefers to play independently
- Plays with toys in an unusual way (spins wheels instead of rolling cars, preference to play with string or another object rather than a toy)
- Likes to play rough

Please describe your child's favorite toys and/or activities: _____
_____

Social History:

Where is your child during the day? _____
_____

Do they attend school? If yes, please provide the name of your child's school, grade level, and school district if applicable). _____
_____

What is their placement (mainstream, life skills, etc)? Do they receive any services or accommodations in their school? _____
_____
_____

Does your child have any siblings? Please list ages. _____
_____

Does your family have any history of speech, language, feeding, or hearing problems? _____
_____
_____

Is there more than one language spoken in the home? Are there any close family members or care takers such as nannies that speak an additional language around your child? _____
_____
_____

Parent Goals for Therapy:
Please list your goals for your child in regards to speech, language, and feeding therapy.
1. _____
2. _____
3. _____
4. _____

Completed by: _____ Relationship to the child: _____
Signature: _____ Date:

Thank-you for taking the time to fill out this form for your child. Your information will greatly assist me to prepare for and complete a thorough evaluation of your child's skills.

Julie Wahrenberger, M.S., CCC-SLP