KEY THERAPY
UNLOCK YOUR POTENTIAL

Patient History

As part of your child's evaluation, please complete the following form. Answer questions as completely as possible. This information is kept confidential and will be used to have a better understanding of your child's needs.

Name:_____

Date of Birth:_____ Age: _____ Sex: Male ☐ Female ☐

Address: :_____

City: _____ State: _____ Zip: _____

Phone: _____

Person Completing This Form: _____

Relationship to Child: _____ Who does the child live with? _____

Mother's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Father's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip:_____

What is the reason you brought the child in today?

_____

_____

_____

_____

_____

W175 N11163 Stonewood Drive. Suite 106, Germantown WI 53022 T: 414 305 8495 F: 414 409 7025

When was the problem first noticed? _____ By whom? _____

Has the problem changed since it was first noticed? _____

Is your child aware of the problem? _____

What is the child's primary language? _____

What languages are spoken at home? _____

Child's pediatrician or family doctor _____

Address: _____

Phone: _____

Other doctor(s) treating the child

_____

Has the child had any previous testing or therapy for speech, language, or hearing problems?
Yes☐ No☐

If yes, name of agency and date tested _____

Does anyone else in the family have speech, language, or hearing problems? Yes☐ No☐

If yes, please describe: _____

_____

_____

List all children in the family from oldest to youngest

Name_____ Age_____ Sex_____ Grade in School_____ General Health _____

Name_____ Age_____ Sex_____ Grade in School_____ General Health _____

Name_____ Age_____ Sex_____ Grade in School_____ General Health _____

Name_____ Age_____ Sex_____ Grade in School_____ General Health _____

Name_____ Age_____ Sex_____ Grade in School_____ General Health _____

Name_____ Age_____ Sex_____ Grade in School_____ General Health _____

Name_____ Age_____ Sex_____ Grade in School_____ General Health _____

BIRTH HISTORY

Mother's health during pregnancy? (illnesses, accidents, medications, bed rest):_____

_____

_____

Length of pregnancy:_____

Weight of child at birth Length of labor:_____

Was the child full term? ☐ Yes ☐ No

Type of birth:

Normal☐ Induced☐ Forceps☐ Caesarean☐ Premature___ How many weeks___ ?

Any issues during labor or delivery? _____

Were there any issues at birth (such as "blueness," jaundice, abnormal shape of head)? Yes No

If yes, please describe:_____

Length of hospital stay for mother:_____baby_____

Additional information:_____

MEDICAL HISTORY

Date of last medical examination: _____

Has your child or relative had any of the following: (list which relatives, e.g. paternal grandfather, etc.)

_____

Speech and language concerns:_____ Hearing loss: _____ Deafness: _____

Cerebral palsy:_____ Mental illness: _____ Tinnitus: _____

Cleft lip/palate: _____ Behavioral problems: _____ Learning problems: _____

Other medical concerns Yes☐ No ☐

If yes, please explain:_____

_____

_____

_____

Is your child subject to frequent colds, sore throats? Yes☐ No ☐

Does your child have allergies? Yes☐ No ☐

If yes, please describe: _____

Does the child tend to breathe with mouth open? Yes☐ No ☐

Has the child had any surgeries? Yes☐ No ☐

If yes, please describe: _____

Has the child had tonsils and adenoids removed? Yes☐ No☐

If yes, when? _____

Has the child had any ear trouble (such as earaches, infection, running ears, evidence of hearing loss)?
Yes ☐ No ☐

If yes, please describe: _____

Has hearing been tested? Yes☐ No ☐

If yes, when? _____

Results: _____

_____

_____

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

If yes, when? _____

If yes, does the child still have ear (PE) tubes? Yes☐ No ☐
Has the child ever worn eyeglasses or had any difficulty with his/her eyes? Yes☐ No☐
If yes, please describe:

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

If yes, please describe: _____

_____

_____

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

If yes, please explain: _____

_____

_____

Has the child had any surgeries? _____ What type and when? _____

DEVELOPMENTAL HISTORY

Did the child have any feeding problems (such as poor control of sucking, food allergies, digestive issues)?
Yes☐ No ☐

If yes, please describe: _____

_____

Did the child have any reflux, significant spitting up or gassiness? Yes☐ No☐

If yes please explain: _____

Did the child nurse of bottle feed? _____any difficulties?_____

Does child have any strong food preferences or avoidances or dislikes of certain food?_____

_____

_____

Did the child coo? Yes☐ No☐ Babble? Yes☐ No☐

Has the child's speech and/or language skills ever regressed or ceased? Ye☐ No ☐

If yes please describe_____

Has the child ever sucked their thumb or used a pacifier? Yes ☐ No ☐

If so which one and for how long? _____

Is the child oversensitive or under reactive to sounds?_____

Does the child have any difficulties sleeping? Yes☐ No☐ snore? Yes☐ No☐

Give ages of development for the following behaviors (the best of your knowledge):

Crawl_____ Sit_____ Walk_____ Eat solid foods_____ Self-fed_____ Dress self _____

Bladder/bowel control _____

Do you feel that the child was late or had difficulty in the development of these behaviors? Yes No

If YES please explain: _____

EDUCATION HISTORY

Current school

Phone number:

Address

City_____ State_____ Zip_____

Grade _____ Teacher _____ Did your child attend daycare? Yes ☐ No ☐

If yes, when? _____

Describe performance in school (please note strong and weak areas) _____

_____

_____

Does the child attend any special classes (such as speech therapy, language development, reading, resource room, special education classroom)? Yes ☐ No ☐

If yes, please describe: _____

_____

_____

Do you have any specific concerns regarding school?_____

_____

_____

_____

_____

DAILY BEHAVIOR

Where does the child usually play? _____

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

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

Does the child prefer to play with older or younger children? _____

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

What are your most frequent discipline problems with this child? _____

_____

_____

_____

Who does the disciplining?_____

How do you discipline? _____

What does the child do well? _____

_____

_____

_____

What does the child have trouble doing?

_____

_____

_____

Does the child have difficulty concentrating?

_____

_____

_____

COMMUNICATION HISTORY

Is the child's speech understandable?

To you: ☐ To friends: ☐ To strangers: ☐ To other family members: ☐

List sounds or words that the child has trouble saying:_____

_____

_____

_____

How does the child's speech or language compare to others his/her peers? _____

_____

_____

_____

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

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

_____

_____

_____

Did the child coo as a baby? _____ babble? _____ When was first words? _____

When was 2 word sentences? _____

When was 3+ word sentences? _____

Does the child follow 1 step directions?_____ 2 step directions?_____

Does the child appear to understand what you are saying?_____

Does the child prefer to use speech or gestures when communicating? _____

Do you have any further Do you have any further questions? _____

_____

_____

_____

_____

_____

_____

Patient or Parent/Guardian Signature Date

_____ _____

Relationship to Patient

_____