Name MRN DOB (Patient Identification)	VCU Health Community Memorial Hospital **SPEECH THERAPY PEDIATRIC HISTORY**

The information provided will assist in planning and providing the appropriate services for your child.
All information will be a part of the child's record and will be confidential.
Information may be stated in the record unless requested that it be kept private.

Child's Name: _____ Date of Birth: _____ Gender ☐ M ☐ F

Child currently resides with: ☐ Both Parents ☐ One Parent ☐ Parent/Step Parent ☐ Foster Parents
☐ Adoptive Parents ☐ Legal Guardian(s) ☐ Other _____

Parents and/or Legal Guardian(s) Names:

_____ _____

☐ Parent ☐ Legal Guardian ☐ Other _____ ☐ Parent ☐ Legal Guardian ☐ Other _____

Home Phone _____ Home Phone _____
Work Phone _____ Work Phone _____
Cell Phone _____ Cell Phone _____

Child's **Address**: _____
Street City State Zip Code

Child's Doctors: _____

Physician's name: _____ Physician's name: _____
Address: _____ Address: _____
Phone #: _____ Phone #: _____

Sisters and brothers in the household:

Name	Age	Grade

Name of person completing this form _____

Relationship to child _____

STATEMENT OF THE PROBLEM

Reason for referral: _____

_____

Describe the problem: _____

DT-SPEECHPATH

Name MRN DOB (Patient Identification)	VCU Health Community Memorial Hospital **SPEECH THERAPY PEDIATRIC HISTORY**

MEDICAL HISTORY

Were there any problems with birth or delivery? ☐ No ☐ Yes

Has your child had any significant illnesses, operations or hospitalizations? ☐ No ☐ Yes

Is there any history of medical concerns? ☐ No ☐ Yes

Circle listed items of concern as appropriate: vision, hearing, use of hands, use of legs, allergies, seizures, ear infections, accidents, injuries, surgeries, colds, infections, enlarged tonsils or adenoids, feeding problems, syndromes

If yes to any of the above, explain: _____

List of all current medications, over-the-counter medications, or herbal supplements your child is currently taking: _____

Does your child have a history of frequent ear infections? ☐ No ☐ Yes

Does your child have ear (PE) tubes? ☐ No ☐ Yes

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

If yes, When: _____ Where (school, clinic, etc.): _____

Results: _____

Is there family history of diagnoses relevant to speech therapy (e.g. stuttering, learning disability? speech/language delay, autism, ADHD, etc.)? ☐ No ☐ Yes

SPEECH AND LANGUAGE DEVELOPMENT

Age child began babbling _____ Age child spoke first words _____

How does your child communicate his/her wants and needs? ☐ Gestures ☐ Words ☐ Both

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

When you point to a toy across the room, does your child look at it? ☐ Yes ☐ No

Does your child engage in pretend play with toys (i.e.,feed a doll) ☐ Yes ☐ No

Does your child speak in sentences? ☐ Yes ☐ No

If yes, about how many words can your children put together? _____

Does your child play with other children of the same age or family members? ☐ Yes ☐ No

DT-SPEECHPATH

Name MRN DOB (Patient Identification)	VCU Health Community Memorial Hospital **SPEECH THERAPY PEDIATRIC HISTORY**

Is your child's speech understood by strangers? ☐ Yes ☐ No

Does your child follow simple directions (e.g. "shut the door" or "get your shoes") ☐ Yes ☐ No

Does your child respond correctly to yes/no questions? ☐ Yes ☐ No

INTEREST INVENTORY

What are your child's interests and favorite activities? _____

_____

_____

Does your child have any fears (e.g. such as stuffed animals, loud noises) _____

_____

EDUCATION

Does your children attend day care? ☐ No ☐ Yes If yes, how often: _____

Where: _____

Where does your child go to school? _____

School District: _____

Grade: _____ Teacher: _____

If your child is in school, are there any concerns about academic performance (e.g., reading, writing, subject areas)? ☐ No ☐ Yes If yes, explain _____

_____

_____

_____

Does your child receive special help in school? ☐ No ☐ Yes If yes, explain _____

_____

_____

Does your child have an IEP? ☐ No ☐ Yes If yes, bring the IEP with you to the evaluation or complete a release of information form for your child's school (if applicable).

_____

_____

DT-SPEECHPATH

Name MRN DOB (Patient Identification)	VCU Health Community Memorial Hospital **SPEECH THERAPY PEDIATRIC HISTORY**

THERAPY

Has your child received Speech Therapy previously? ☐ No ☐ Yes If yes, when: _____

If yes, When: _____ Where (school, clinic, etc.): _____

Results: _____

_____

Is your child currently receiving:

Speech Therapy? ☐ No ☐ Yes

If yes, how often: _____ Where _____

Occupational Therapy? ☐ No ☐ Yes

If yes, how often: _____ Where _____

Physical Therapy? ☐ No ☐ Yes

If yes, how often: _____ Where _____

Is there anything else you wish to add that would help insure a positive testing experience for your child?

_____

_____

_____

Please add any additional comments or concerns you have. _____

_____

_____

_____

If your child has received special help at school or from other professionals, please bring any reports you have to the evaluation. In addition, copies of your child's IEP (Individualized Education Plan) from the school, if you have them, would be helpful to us in meeting your child's needs.

Thank you very much for your help and for the information you provided in this case history form. If you have questions before your intake or initial appointment, please contact the Speech-Language Pathologist at VCU Health Community Memorial Hospital at (434) 447- 0895.

_____ _____ _____

Signature of Person Completing Form Date Time

_____

Relationship to Patient

_____ _____ _____

Name/Signature of Reviewing Speech-Language Pathologist Date Time

DT-SPEECHPATH