Patient History Questionnaire DATE: _____

Patient Name:_____ Gender: _____ Age/DOB:_____
Social Security Number: _____
Parents'/Guardians' Names:_____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Secondary Phone: _____
Emergency Contact, Number, Relationship: _____
Primary Care Physician:_____ City/Phone of PCP:_____
Referral Source (if different):_____ Previous Testing: PT / OT / ST Other: _____
Previous Therapy Services Received from: _____
Most Recent Hearing Screening: _____ Passed: Yes / NO

INSURANCE INFORMATION:
Insurance #1: _____ Policy Number: _____
Insured: _____ Relation to Pt: _____
Insured's SSN:_____ Insured's Date of Birth:_____
Group Name: _____ Group Number: _____
Insured's address, if different from above:
_____
_____
Insurance #2: _____Policy Number: _____
Insured: _____Relation to Pt: _____
Insured's SSN:_____ Insured's Date of Birth:_____
Group Name: _____ Group Number: _____
Insured's address, if different from above:
_____
_____

Family Information:
Language(s) spoken in the home:_____
Names and ages of siblings:_____
Names and types of pets:_____
Names and relationships of others living in home: _____

Primary Concerns (Please list any information you would like for us to know): _____
_____
_____

Developmental Milestones (At what age did your child begin the following):
Sitting w/o support: _____ Crawling: _____ Walking: _____ Talking: _____
Talking in phrases: _____ Talking in sentences: _____ Hand dominance: R / L / Not Sure