Print Form

HISTORY AND INFORMATION FORM
PRINT OR FAX TO: 603-893-8680

Identification Information

Current Date: _____

Child's name: _____ Child's date of birth: _____

Mother's name: _____ Phone : _____ Cell: _____

Father's name: _____ Phone : _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's occupation: _____ Phone : _____ email _____

Father's occupation: _____ Phone : _____ email _____

Language(s) spoken in the home: _____

Siblings' ages: _____

Child's diagnosis: _____

Referring physician: _____ Phone : _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Company: _____ Phone : _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____

Identification #: _____ Policy #: _____ Group #: _____

Is this person covered under another insurance policy?: _____ (If no, skip secondary insurance)

Secondary Insurance Company: _____ Phone : _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____

Identification #: _____ Policy #: _____ Group #: _____

Statement of the Problem

Reason for referral:

Describe what you perceive as your child's speech and/or language problem:

What if anything has been done about the problem prior to now:

When did you first notice a difference in your child's speech and/or language development:

What would you like to see done about your child's speech and/or language problem:

What are some of the questions that you would like answered about your child's problem:

Medical and Developmental History

Duration of pregnancy:

Were there any complications during pregnancy? (If so, please describe):

Vaginal or Cesarean (Planned or Emergency) delivery?:

Duration of labor: Birth weight: APGAR scores:

Was there any special care given to the baby after birth? (If so, please describe):

Is your child currently taking any medications? (If yes, what medication, how often, and why):

Has your child ever been hospitalized? (If so, when and for what reason):

Has your child ever been diagnosed as having any of the following disorders or problems:

- ☐ Hearing impairment
- ☐ Learning disabilities
- ☐ Dyslexia
- ☐ Cleft lip/palate
- ☐ Visual impairment
- ☐ Ear infections
- ☐ Kidney disorder
- ☐ Blood disease
- ☐ Epilepsy or other seizure disorder
- ☐ Heart disorder
- ☐ Allergies
- ☐ Cerebral Palsy
- ☐ Muscular Dystrophy
- ☐ Emotional disorders
- ☐ Autism

Other: _____

If you checked any of the above, please explain. _____

Please check any of the following that apply to your child now or in the past (please indicate age):

Temper tantrums: _____ Nightmares: _____ Separation problems: _____

Perfectionist: _____ Awkward or clumsy: _____ Easily excitable: _____

Melancholy/Sad: _____ Bedwetting: _____

Overly active: _____ Under active: _____

Describe your child's general health. _____

Are your child's immunizations up to date?: _____

Has your child's hearing been tested?: _____

When: _____ Where: _____

Results: _____

Has your child's vision been tested?: _____

When: _____ Where: _____

Results: _____

Is your child now receiving special care from a physician, psychologist, speech-language pathologist, occupational therapist, physical therapist, or other health professional?

Is there any family history of:

Relationship to the child

Hearing problems?:

Learning problems?:

Speech-Language problems?:

Emotional problems?:

Mental retardation?:

Other:

Did you feel that you child was slow, average, or rapid in his/her development up to 3 years of age?

Speech and Language Development

Please indicate the age, in months, at which your child did the following:

Made cooing sounds:

Said first word

Used two words together:

Used simple sentences:

Does your child use most sounds correctly?

Do you understand most of what your child says?

Do other people understand your child?

If no, does your child show frustration when not understood?

Has your child commented that it is difficult to talk?:

Do others tease him/her?

Does your child understand what is said to him/her?

Motor Development

Please indicate the age, in months, at which your child did the following:

Sat unsupported:	_____	Crawled on hands & knees:	_____
Rolled over:	_____	Walked alone:	_____
Dressed self:	_____	Tied shoelace:	_____
Colored pictures, within lines:	_____	Potty trained:	_____

Does your child prefer to use his/her right or left hand? _____

Does your child have a tendency to switch hands? (explain below) _____

_____

Check all that apply to your child's motor skills:

- ☐ Seems weaker than others his/her age (tires easily)
- ☐ Difficulty with hopping, skipping, running, jumping compared to others his/her age
- ☐ Movements are stiff and awkward
- ☐ Clumsy, bumps into things
- ☐ Pencil/coloring activities are better than large motor activities
- ☐ Large motor activities are better than pencil/coloring activities
- ☐ Motor skills seem average compared to others his/her age
- ☐ Enjoys puzzles, building with legos, etc.

Indicate if your child experienced any of the following:

- ☐ Excessive choking on foods
- ☐ Sensitivity to specific textures (which ones)
- ☐ Sensitivity to specific temperatures
- ☐ Excessive gagging

Speech THERAPY SOLUTIONS, INC.

Educational and Social Information

Name of school/daycare: _____ Phone : _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Has your child ever repeated or skipped a grade in school?
(If yes, which grade and which grade and why?

_____

Does your child excel in any subjects?
(If so, which ones)

_____

Has your child ever received instruction, tutoring, therapy, or special placement outside of the regular classroom? (If yes, please explain)

_____

How does your child feel about his/her school or teacher?

_____

How does your child get along with other children?

_____

Do you think your child's motor skills are in advance of his/her language skills?

_____

Do you think your child's language skills are in advance of his/her motor skills?

_____

Has your child been tested in any of the following areas:

Speech Language Evaluation?: _____

When: _____ Where: _____

Academic Evaluation?: _____

When: _____ Where: _____

Psycho-Educational Evaluation?: _____

When: _____ Where: _____

Occupational Evaluation? _____

When: _____ Where _____

Physical Therapy Evaluation?: _____

When: _____ Where: _____

How does your child amuse him/herself when alone? _____

What are your child's favorite play activities? _____

Other Information

How did you hear about Speech Therapy Solutions?

- ☐ Referral
- ☐ insurance company
- ☐ printed phonebook
- ☐ online phonebook
- ☐ webpage

Person completing this form: _____

Relationship: _____

_____ Date _____

Signed By