

Speech Therapy
Parent Information Form

Child's Name: _____ Date of Birth: _____

Allergies: _____ Fall risk: ___yes ___No

Medications ___Yes___No

***please list prescription/over the counter, herbs/vitamin supplements

Medical diagnosis: _____

Reason for Referral: _____

Medical History

Birth Weight ___lbs ___oz gestation: _____

Date of last physical exam: _____ Results: _____

Natural child? _____ Adopted child? _____ Other: _____

How many pregnancies? _____ number of live births _____ miscarriages _____

Describe any problems experienced during pregnancy/delivery: _____

Please comment on exposure to infection, toxic substances or accidents during the pregnancy.

Single Birth ___yes ___no Length of labor: _____

Type of delivery: _____

Baby's condition at birth: _____

Length of hospital stay: _____

Please list any surgeries: Type: _____ Date: _____

Type: _____ Date: _____

Has your child had:

Ear infections ___Yes ___No If yes, how many? _____

Hearing testing ___Yes ___No Testing date: _____ results: _____

Vision testing ___Yes ___No Testing date: _____ results: _____

Special diet(s) ___Yes ___No Please list: _____

Nutritionist ___Yes ___No If yes, reason: _____

Developmental History

Please put ages obtained next to the developmental milestones obtained below.

Example: Rolled over-3 months

rolled over _____ said first word _____

held a toy _____ used sentences (3-4 words) _____

sat alone _____ fed self using a spoon _____

crawled _____ removed clothing _____

stood alone _____ bladder control _____

walked _____ bowel control _____

Sleep Habits

Does your child sleep through the night? ___Yes ___No

If yes, please describe: _____

Feeding

Are there any feeding/eating concerns? ___Yes ___No

If yes, please describe: _____

Speech/Language Concerns (Pleas check all that apply and comment as necessary)

- ___delayed speech ___stutters ___trouble finding words
- ___frequently mispronounces ___trouble being understood by others
- ___trouble expressing self easily ___difficulty following directions

Comments: _____

Is any other language spoken in the home? If yes, what? _____

Temperment (please check all that apply and make comments as necessary)

- ___quiet ___restless ___active ___affectionate ___whining
- ___withdrawn ___easily frustrated ___impulsive ___impatient

Does your child have any unusual fears, habits, routines ___Yes ___No

If yes, please describe: _____

Does your display any of the following behaviors?

- ___head banging ___breath holding ___hair twirling ___teeth grinding
- ___other: _____

Comments: _____

Behavior: (Please check all that apply to your child)

- ___speech problems ___reading problems ___slow learner
- ___short attention span ___poor coordination ___fine motor problems
- ___temper tantrums ___short attention span ___hyperactive
- ___unsteady /awkward gait ___destructive behavior ___other: _____

Comments: _____

Discipline:

Who disciplines your child? _____

What methods are effective? _____

Does your child interact well with other children? ___Yes ___No

Comments: _____

How does your child occupy his/her time at home? _____

Extracurricular Activities (check all that apply)

- ___swimming ___basketball ___soccer ___football ___choir ___dance
- ___gymnastics ___baseball ___softball ___hockey ___martial arts
- ___boy/girl scouts ___therapeutic horsemanship ___other: _____

Preschool/School-Aged Children

Is your child:

right handed left handed uses both hands about the same

Does your child attend school: Yes No

School name: _____ Hours: _____

Does your child have regular attendance? Yes No

If no, please explain: _____

Has your child ever repeated a grade? Yes No If yes, which one? _____

Please check all of the following that apply to your child's attitude towards teachers

very fond friendly indifferent dislikes

unfriendly fearful unknown teased

other: _____

Does your child do well with school work? Yes No

Comments: _____