TRENKA SPEECH-LANGUAGE SERVICES
Patient History Information

Thank you for taking the time to fill out this form as completely and honestly as possible. Your input plays an important role in the evaluation process. All the information on this form is confidential and will not be released without your permission.

IDENTIFYING INFORMATION			
Date:			
Person Completing Form:	Relationship to Patient:		
Patient's Name:	Date of Birth:	Age:	Sex:
What do you hope to gain from this evaluation?			

FAMILY BACKGROUND	
Mother's Name & Age:	Father's Name & Age:
Occupation:	Occupation:
Work Phone:	Work Phone:
Is this child: ___ Your biological child ____ Adopted Child ____ Foster Child ____ Step Child	
If not your biological child, at what age did he/she come into your home:	
Person's living in the home (siblings, relatives, etc., please list ages):	
Language spoken in the home:	Is an interpreter needed for this appointment? Y / N
Does anyone related to this child have speech, language, hearing, learning, or physical development problems? Y / N If yes, please describe:	

BIRTH HISTORY

Length of pregnancy with this child: _____ weeks

Did mother experience any of the following during pregnancy?

- ☐ Excessive Illness
- ☐ Emotional Upsets
- ☐ Exposure to drugs/alcohol
- ☐ Flu
- ☐ Injury
- ☐ Marked Swelling of Hands/Feet
- ☐ Bleeding/Spotting
- ☐ Rh Incompatibility

How would you describe the labor (check all that apply)

- ☐ Easy labor, spontaneous onset
- ☐ Vaginal birth experience
- ☐ Forceps/suction used
- ☐ Hard labor
- ☐ Breech presentation
- ☐ C-section delivery
- ☐ Induced labor

Condition of infant immediately after birth (check all that apply)

- ☐ Normal, no problems
- ☐ Difficulty with feeding, sucking, swallowing
- ☐ Breathing problems
- ☐ Jaundiced
- ☐ Birth Injury
- ☐ Congenital differences

Measurements of the child: Weight _____ Length: _____

Did any of the following occur during infancy?

- ☐ Excessive Crying/Colic
- ☐ Difficulty feeding/sucking/swallowing
- ☐ Injury
- ☐ Breathing problems/respiratory illness
- ☐ Other: _____ _____

If so, please explain:

HEALTH / MEDICAL HISTORY

Is the child currently in good health? ☐ Yes ☐No

Is the child taking any medications? ☐ Yes ☐No

If yes, please list medication(s), dosage, and why used:

Has the child seen the following specialists? (check all that apply)

- ☐ Neurologist
- ☐ Psychiatrist
- ☐ Opthalmologist and/or Vision Therapist
- ☐ Orthopedic Surgeon
- ☐ Ear/Nose/Throat Specialist
- ☐ Psychologist
- ☐ Other

Explain reason child is seeing specialist(s):

Please include names and phone numbers of specialist(s):

Has the child ever had an operation or been hospitalized? ☐ Yes ☐No

Dates/Surgery/Hospital:

Dates/Surgery/Hospital:

Do you have concerns regarding your child's hearing? ☐ Yes ☐No

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

If yes, number of ear infections per year:

When and where was your child's most recent hearing test?

Please list results of testing:

Does the child have any allergies? ☐ Yes ☐No

If yes, please list:

COMMUNICATION DEVELOPMENT
Describe the child's communication difficulties:
Did the child make babbling/cooing sounds prior to saying words? □ Yes □No
At what age did the child say his/her first word?
Does anyone have trouble understanding the child? □ Yes □No
Does the child have difficulty producing specific sounds? □ Yes □No
Does the child respond to speech and/or different sounds in the environment? □ Yes □No
Does the child follow directions? □ Yes □No If yes, please provide an example:
Does the child initiate communication with others? □ Yes □No
Does the child talk □ More □Less □ The Same as children his/her age?
Does your child play and engage socially with other children his/her age? □ Yes □No
Does the child play □ With □Next To □ Alone □ or Avoid other children?
Does the child maintain eye contact while communicating? □ Yes □No
How does the child communicate (gestures, single words, short phrases, etc.)? Please give examples:
How many words does your child typically put together in one utterance?
Does the child appear to be aware of his communication difficulties? □ Yes □No If yes, please explain:

FEEDING HISTORY
Does the child have strong food preferences? □ Yes □No If yes, please explain:
Does the child drool? □ Yes □No
Does child breathe with mouth open or closed?
Does/did the child suck their thumb or use a pacifier? □ Yes □No
Does the child have a strong gag reflex? □ Yes □No
How many teeth does the child have?
Has your child seen a dentist? □ Yes □No Provider Name:

DEVELOMENTAL HISTORY
Do you have any concerns regarding the child's motor development? □ Yes □No If yes, please explain:
Do you have any concerns regarding the child's emotional / social development? □ Yes □No If yes, please explain:
Do you have any concerns regarding the child's behavior? □ Yes □No If yes, please explain:
How would you explain your child's personality?
Please add comments and/or attach any information that would be helpful in understanding the child's communication abilities:

ACADEMIC / THERAPY HISTORY		
Does your child attend school? □ Yes □No If yes, name the school:		
Phone Number:	Grade Level:	Name of Teacher:
Type of classes attended:		When did the child begin school?
Does your child receive the following services at school? (check all that apply)		
Therapy □ Yes □No If yes, what kind?		
Special Education Classes □ Yes □No If yes, what kind?		
Special Testing □ Yes □No If yes, what kind?		
List other therapists/specialists your child has seen:		
Name/ Address	Testing / Treatment Given	Dates of Service
_____ _____ _____	_____ _____ _____	_____ _____ _____