SPEECH THERAPY ASSOCIATES

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Medical and Developmental History

This information will be used for Evaluation purposes and for creating effective Treatment plans.

Family

Spouse or Parents: ________________________ ________________________
Employment: ________________________ ________________________
Siblings or children and ages: ____

Medical and Educational

Physician:____
Dentist: ____
Orthodontist: ____
Speech-Language Pathologist: ____
Other: ____
School: ____
Grade: ____
Dietary restrictions/food allergies: _______________________________________

Oral Habits and History

Breathing through mouth: No_______ Day _______ Night _______ Both ______
Frequent colds: No ___ Yes ____
Allergies: No ___ Yes ____
Sore throat/Strep: No ___ Yes ____
Bronchitis: No ___ Yes ____
Sinusitis: No ___ Yes ____
Pneumonia: No ___ Yes ____
Choking or coughing during eating: No ___ Yes ___________________________

Digit Sucking: No______ Yes (describe) ___________________________
Nail biting: No______ Yes (describe) ___________________________
Lip biting: No______ Yes (describe) ___________________________
Object chewing: No______ Yes (describe) ___________________________

Musical instruments: ____

Interests: ____

____

Hearing and Health:

Family history of hearing loss: ____
Number of ear infections as child: _______________________________________
Treatment: ____

High fever: ____
Hospitalization: ____
Falls or other trauma to head: ____

____
Falls or other trauma to mouth and oral areas: ______________________________

____
History of Speech or Language delays: ___________________________________

____
Tonsils or Adenoids removed: ____
Snoring: ____
How would you like to learn new information (discussing, reading, try with support, etc.)? ____

Please describe any relevant current or past treatments or therapy (speech, ABA, swallowing, OT, etc.): ____

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____

Is there anything else you would like us to know?

____

For Children:
Birth History
Born: at term_____ weeks before due date_______ weeks after due date_____
Weight: ________________________
Complications during birth: ____

____
Health of mother during pregnancy: ______________________________________
Medications taken during pregnancy: _____________________________________
Exposure to any of the following during pregnancy: tobacco_____ alcohol____
non-prescription drugs________________________
other:__________________________
Physical trauma during pregnancy: _______________________________________
Breast feeding (how long): ____
Bottle feeding (how long): ____
Infant feeding difficulties: ____

____

Approximate ages for the following:
cooing: ___________________________ turn over: _________________________
sit without support: _________________
crawl: _____________________________ first steps: ________________________
age of first words: _________________ what were they? ___________________
combine two words: ____