CanDoKids
Therapy Services, LLC
484-891-1226
grow@candokidstherapy.org

# PATIENT HISTORY

Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Person Completing This Form: _____

Relationship to Client: _____

Mother's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Mother's Occupation: _____

Employer: _____

Education Completed: _____

Father's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Father's Occupation: _____

Employer: _____

Education Completed: _____

**List all children in the family from oldest to youngest**

| Name | Age | Sex | Grade in School | General Health |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| | | | | |

Does anyone else in the family have speech, language, or hearing problems? ☐ Yes ☐ No

If yes, please describe: _____

Who referred you for the evaluation? _____

Child's pediatrician or family doctor _____

Address _____

Other doctor(s) treating your child

_____

Has your child had any previous testing or therapy for speech, language, or hearing problems?
☐ Yes ☐ No

If yes, name of agency and date tested _____

Why are you bringing your child to see us today?

_____

_____

**BIRTH HISTORY**

Weight of child at birth _____ Was your child full term? ☐ Yes ☐ No

Were there any unusual factors relating to the pregnancy (such as toxemia, X-ray treatments, RH negative, German measles, other illnesses, drugs or medications, previous miscarriages)?

☐ Yes ☐ No

If yes, please describe:

_____

_____

Type of birth:

☐ Normal ☐ Induced ☐ Forceps ☐ Caesarean ☐ Premature; How many weeks?

Were there any physical deformities or malformations observed at birth (such as "blueness," jaundice, abnormal shape of head)? ☐ Yes ☐ No

If yes, please describe: _____

## DEVELOPMENTAL HISTORY

In early childhood, did your child have any feeding problems (such as poor control of sucking, food allergies, digestive upsets)? ☐ Yes ☐ No

If yes, please describe: _____

Give ages of development for the following behaviors:

| | | | |
|---|---|---|---|
| Sitting unsupported | _____ | Walking | _____ |
| Eating solid foods | _____ | Self-feeding | _____ |
| Crawling | _____ | Self-dressing | _____ |
| Standing alone | _____ | Bladder/bowel control | _____ |

Do you feel that your child was late or had difficulty in the development of these behaviors?

☐ Yes ☐ No

## MEDICAL HISTORY

Date and type of last medical examination _____

List ages for any of the following childhood diseases:

| | | | |
|---|---|---|---|
| Whooping cough | _____ | Pneumonia | _____ |
| Mumps | _____ | Chicken Pox | _____ |
| Measles | _____ | Tonsillitis | _____ |
| Rheumatic fever | _____ | Other: | _____ |

Were there any complications with any of the above, such as high/persistent fevers, convulsions, or persistent muscle weakness? ☐ Yes ☐ No

If yes, please explain: _____

Is your child subject to frequent colds, sore throats? ☐ Yes ☐ No

Has your child had allergies, hay fever, etc.? ☐ Yes ☐ No

If yes, please describe: _____

Does your child tend to breathe with mouth open? ☐ Yes ☐ No

Has your child had any operations? ☐ Yes ☐ No

If yes, please describe: _____

Has your child had tonsils and adenoids removed? ☐ Yes ☐ No

If yes, when? _____

Has your child had any ear trouble (such as earaches, infection, running ears, evidence of hearing loss)? ☐ Yes ☐ No

If yes, please describe: _____

Has hearing been tested? ☐ Yes ☐ No If yes, when? _____

Results: _____

Has your child ever had ear (PE) tubes inserted? ☐ Yes ☐ No

If yes, when? _____

If yes, does your child still have ear (PE) tubes? ☐ Yes ☐ No

Has your child ever worn eyeglasses or had any difficulty with eyes? ☐ Yes ☐ No

If yes, please describe: _____

Does your child have any dental problems? ☐ Yes ☐ No

If yes, please describe: _____

Has your child seen a specialist for any reason? ☐ Yes ☐ No If yes, please explain:

_____

_____

## EDUCATION HISTORY

Current School _____

Address _____

City _____ State _____ Zip _____

Grade _____ Teacher _____

Did your child attend nursery school? ☐ Yes ☐ No

If yes, when? From age _____ to age _____

At what age did your child attend kindergarten? _____

Does your child like school? ☐ Yes ☐ No

Does your child like the teacher? ☐ Yes ☐ No

Describe performance in school (please note strong and weak areas)

_____

Does your child attend any special classes (such as speech therapy, language development, reading, resource room, special education classroom)? ☐ Yes ☐ No

If yes, please describe:

## DAILY BEHAVIOR

Where/how does your child usually play?

Are there children close to your child's age in the neighborhood? ☐ Yes ☐ No

Does your child prefer to play alone? ☐ Yes ☐ No

Does your child prefer to play with older or younger children?

Does your child have a close friend? ☐ Yes ☐ No

What are your most frequent discipline problems with this child?

Who does the disciplining?

How do you discipline?

What does your child do well?

What does your child have trouble doing?

Does your child have difficulty concentrating?

## COMMUNICATION HISTORY

Is your child's speech understandable to you? ☐ to friends? ☐ to strangers? ☐ to other family members? ☐

Are there sounds or words that your child has trouble saying?

How does your child compare with siblings in speech development?

Does your child use words in meaningful ways for his/her age? ☐ Yes ☐ No

Give examples of sentences your child uses by himself/herself (not sentences that are repeated after you):

At what age did your child babble? _____ say first words? _____

put two words together in a sentence? _____ use three-word sentences? _____

Does your child seem to understand directions? ☐ Yes ☐ No

Does your child prefer to use speech or gestures when communicating?

Do you have any further questions?

_____
Patient or Parent/Guardian Signature

_____
Relationship to Patient

_____
Date