

JABBERDOGS

SPEECH & OT

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MEDICAL HISTORY FORM

In your own words, what is the child’s difficulty, and what do you think may have caused it?

When did you first notice the problem? _____

Pediatrician: _____ Phone: _____

Current Medications: _____

Other doctors (dentist/orthodontists/psychologists) that provide care to this child:

Name	Specialty	City
_____	_____	_____
_____	_____	_____

Previous evaluations (list): _____

Diagnosis: _____ Made by: _____ When: _____

Has your child received any therapy to date (list) How long? By whom? Has your child been seen by an OT and/or PT?

Prenatal/Birth History

Please check all that apply

Normal pregnancy and birth Full term If no, how many weeks? _____

- vaginal cesarean breech feet first induced labor premature multiple births NICU
 jaundice low APGARS complications/illnesses during pregnancy poor health or injury
 at birth problems sucking problems breathing at birth oxygen required
 fed via breast, bottle, non-oral poor weight gain any concerns that may have affected
 gestation/birth? (respiratory, circulatory, gastrointestinal) _____

Medical History

- seizures high fevers Autism ADHD Down Syndrome encephalitis pneumonia
 tonsillitis concussions/head trauma enlarged glands chronic colds heart trouble
 asthma sensory disorder developmental delay anxiety constipation reflux/vomiting
 recurrent/serious illnesses operations accidents vision problems hearing difficulty
 audible breathing open mouth posture mouth breathing chronic congestion sinus
 infections mouths objects/fingers/clothing etc. other _____ allergies _____

Has your child had ear infections? List frequency and severity. Were antibiotics effective in treating the problem?

Has your child had hearing testing or tympanometric testing? When? Does your child have tubes in his/her ears? Do you have any concerns about testing?

Developmental History

Has your child had any feeding difficulties? Check each item that applies:

- Sucking or nursing excessive length of time to drink bottle regurgitation of liquids or
 solids through the nose food refusal gags frequently resistant to new foods coughs
 during meals tongue thrust constipation vomiting food allergies
 diet restrictions/medically ordered weight loss poor weight gain reflux difficulty
 chewing or swallowing meats

Does your child choke while eating? Y/N What foods? _____

Is your child a picky eater? Y/N What type of foods does s/he prefer? _____

Does your child drool more than other child his/her age? Y/N

Does your child use a pacifier? Y/N

Does your child use a sippy cup? Y/N

Age when child: (If you can't remember specific times, please indicate if it occurred at the expected time or was delayed).

Sat up alone _____ crawled _____ walked _____ make wants known _____

Eat pureed fruits/veggies _____ eat pureed meats _____ eat raw fruits/vegetables _____

Used a straw _____ used cup without lid _____

Language Development

Which of the following best describes your child's speech?

- easy to understand
- difficult for parents to understand
- difficult for others to understand
- almost never understood by others
- different from other children of the same age

Which of the following best describes your child's reaction to his/her speech?

- is easily frustrated when not understood
- has been teased about their speech
- does not seem aware of speech/communication problem
- tries to say sounds or words more clearly when asked
- is successful in saying sounds or words more clearly when s/he tries

Does your child have difficulty producing certain sounds? Y/N

Which ones? _____

Has your child received speech treatment? Y/N How long? _____ By whom? _____

Describe what it is like to have a conversation with your child?

Languages spoken at home: _____

Does your child have difficulty following directions? _____

Are there any speech or hearing problems in the immediate or extended family (please explain)?

Please check any developmental milestones that were **not** met at the appropriate developmental age:

Cooing Babbling Single Words Phrases Short sentences

Does/did your child exhibit any of the following behaviors?

Excessive Shyness Y/N

Thumb/Pacifier Sucking Y/N

Difficulty separating from parents Y/N

Difficulty sitting still Y/N

Inability to complete activities Y/N

Attention problems Y/N

Does your child play well with other children? Do you have any concerns about child's play?

Does your child have any academic difficulties?

Did your child's speech/language development seem to develop normally and then stop or regress?

Does your child often hesitate and/or repeat sounds/words?

Is your child's speech too fast _____, too slow _____, or average _____?

Is your child's voice too soft _____, too loud _____, average loudness _____, hoarse _____, nasal _____, other _____?

School History

Educational Setting	Location/School	Teacher	Special Services
Infants and Toddlers			
Childcare Facility			
Preschool			
Elementary School			
Middle School			
High School			

Completed by (Please sign) _____ Date _____

**** Please return this form along with copies of previous evaluations, educational plans or other reports you would like us to consider when assessing your child. ****