Suburban Pediatric
Speech & Feeding Consulting
Treating Kids Right

Patient History

SUBURBAN PEDIATRIC SPEECH AND FEEDING CONSULTING

Patient's Name: _____

Date of Birth: _____Today's Date: _____

Is your child/Patient Adopted or a Foster Child? Yes No

Where was your child adopted from? _____

Therapy Service(s) Requested: Speech Occupational Physical

Please check the reason for Evaluation for Main Concern:

☐	Articulation	☐	Sensory
☐	Receptive Language	☐	Fine Motor
☐	Expressive Language	☐	Mobility
☐	Stuttering	☐	Gross Motor
☐	Voice	☐	Self-Care Skills
☐	Feeding	☐	Other

General/Family Information

Mother's Name: _____ Father's Name: _____

Occupation: _____ Occupation: _____

Mailing Address: _____ Mailing Address: _____

Home Phone #: _____ Home Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

Work #: _____ Work #: _____

Email: _____ Email: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____ Practice Name: _____

Parents (please circle): married separated divorced re-married

Please list names and ages of any siblings living in the home:

Have there been any instances of the following in the immediate or extended family:

- ☐ Autism
- ☐ ADHD
- ☐ Learning Disabilities
- ☐ Hearing Loss
- ☐ Speech-Language Delays
- ☐ Neurological Disease
- ☐ Syndromes

MEDICAL HISTORY

What is your child's current height and weight?

Patient's primary care physician name & phone number:

Does your child see any other physicians/specialists that you would like us to know about?

Does your child have a medical diagnosis? If yes, please state.

List any previous Medical/surgical procedure and/or hospitalizations (include date and explain).

Has your child ever been exposed to a contagious illness or required contact isolation (CMV, MRSA, TB)? If so please explain.

List any medications your child currently takes.

List any food, drug, or latex **allergies** your child has.

What is your main concern regarding your child?

Has your child received any type of therapy before? (Physical, Occupational, Speech) If so, where and for how long

Please describe your child's temperament.

Has your child been diagnosed with or had any of the following: (check all that apply):

- ☐ Allergies
- ☐ Attention Disorder
- ☐ Arthritis
- ☐ Autism/Pervasive Developmental Disorder
- ☐ Chronic Ear Infections
- ☐ Diabetes
- ☐ Nerve Injury
- ☐ High Fevers
- ☐ Speech/Language Delay
- ☐ Auditory Processing Disorder
- ☐ Congenital Disorder
- ☐ Meningitis
- ☐ Heart Disease
- ☐ Developmental Delay
- ☐ Orthopedic Injuries
- ☐ Brain Injury
- ☐ Cerebral Palsy
- ☐ Sensory Processing Disorder
- ☐ Respiratory Difficulties
- ☐ Gastrointestinal Disorder
- ☐ Seizures
- ☐ Behavioral/Psychological Disorder
- ☐ Learning Disorder

PREGNANCY AND BIRTH HISTORY

What was your child's birth weight?

Were there any complications during the pregnancy?

Was your child born at full term?

Were any of the following complications during or after birth?

- ☐ Assisted delivery
- ☐ Cesarean
- ☐ Congenital Defects
- ☐ Jaundice
- ☐ Need for oxygen
- ☐ Transfusions
- ☐ Respiratory difficulties
- ☐ NICU
- ☐ Feeding difficulties (sucking, swallowing)
- ☐ Hypotonia
- ☐ Tube feeding
- ☐ Supplemental nutrition

SELF HELP SKILLS

	Independent	Needs Help
Toileting		
Bathing		
Dressing		
• Shirt		
• Pants		
• Shoes		
• Socks		
Tie Shoes		
Buttoning		
Zipping		
Snapping		

	Independent	Needs Help
Brushing Teeth		
Brushing Hair		

Eating	
• Finger Foods	
• Utensils	
• Fork	
• Spoon	
Drinking	
• Open cup	
• Sippy Cup	
• Straw	

Comments:

DEVELOPMENTAL HISTORY

(check those that are performed and age at which they were performed)

_____lift head when lying on stomach
_____roll over stomach to back
_____roll over back to stomach
_____sit up when placed
_____sit up independently
_____crawl on belly
_____creep on hands or knees
_____pull to stand
_____walk independently
_____hold a pencil/make markings
_____coo prolonged verbal sounds
_____babble repeated syllables
_____speak first word
_____put two words together

Comments:

SENSORY

Does your child exhibit any of the following? (check all that apply)

- ☐ Avoid playing with messy things
- ☐ Object to being touched
- ☐ Appear to be irritated by certain clothing
- ☐ Have trouble being close to others
- ☐ Discriminate odors
- ☐ React negatively to smell
- ☐ Act as though all foods taste the same
- ☐ Dislike bathing
- ☐ Avoid using hands
- ☐ Overreact to having his/her face washed
- ☐ Tolerate teeth brushing
- ☐ Chew on non-food substances
- ☐ Explore by smelling

BODY AWARENESS

Does your child exhibit any of the following? (check all that apply)

- ☐ Hold his/her hands in a strange position
- ☐ Unintentionally push/hit others when intending to express affection
- ☐ Have difficulty assuming or sustaining a grasp on a pencil or a crayon
- ☐ Drop things or bump into things frequently
- ☐ Unintentionally break things/toys
- ☐ Have difficulty with drawing or handwriting

MOVEMENT & BALANCE

Does your child exhibit any of the following? (check all that apply)

- ☐ Rock himself/herself
- ☐ Avoid movement activities
- ☐ Like merry go rounds or spinning
- ☐ Prefer seated activities and appear reluctant in playground with other children
- ☐ Squat to stand
- ☐ Catch a ball
- ☐ Walk on his/her toes
- ☐ Have trouble walking up or down stairs
- ☐ Have difficulty hopping, jumping, or running
- ☐ Jump excessively
- ☐ Appear to have good balance
- ☐ Show fear of playground equipment
- ☐ Jump up from the floor
- ☐ Throw a ball
- ☐ Have difficulty cutting
- ☐ Get car sick
- ☐ Like being tossed in the air
- ☐ Hop on one foot
- ☐ Kick a ball
- ☐ Hold a pencil in a 3-point grasp
- ☐ Ride a tricycle
- ☐ Ride a bike with training wheels
- ☐ Ride a bike without training wheels
- ☐ Has frequent falls
- ☐ Able to climb on age appropriate playground equipment
- ☐ Frequent falling
- ☐ Appears clumsy

Comments:

SPEECH AND LANGUAGE

What is the primary language spoken at home?

Are there any other languages spoken in the home?

Currently or previously enrolled in speech therapy program?

How does your child communicate what he/she wants? (check all that apply)

- ☐ Cries
- ☐ Uses a few words
- ☐ Grunts
- ☐ Says two or three word combinations
- ☐ Uses gestures
- ☐ Points
- ☐ Makes different sounds
- ☐ Uses long sentences

What does your child do when he/she needs help with something?

What happens if you can not figure out what your child is asking for? What does your child do?

When you talk to your child, how much does he/she understand? (check all that apply)

- ☐ Non-responsive
- ☐ Simple directions
- ☐ Everything I say
- ☐ Almost everything I say
- ☐ A few words
- ☐ Simple questions
- ☐ Many words and phrases

Does anyone in your family talk to your child or interpret his/her speech/gestures?

Can people outside your family understand your child's speech?

Did your child's speech and language develop and then seem to stop?

Does your child sometime speaks phrases heard in the past, yet repeats them out of context?

HEARING

Has your child had surgery to place tubes in the ears? If so when?

Does your child talk in a loud voice or turn up the volume on the TV/radio?

Has your child had a hearing test? If so, when and what were the results?

FEEDING

Do you have any concerns regarding feeding/swallowing?

Has your child ever required supplemental nutrition via NG/G tube or intravenous?

Did your child nurse? How long? Why discontinued?

Does your child take a bottle? How long? Why discontinued?

Does your child have swallowing problems?

Has your child ever had a swallow study? If so, when, where, and what were the results?

How is your child currently fed?

- ☐ Totally by mouth
- ☐ Totally by NG/G tube
- ☐ NG/G & Oral
- ☐ Baby food
- ☐ Breast only
- ☐ Bottle only
- ☐ Table food

What types of foods are the easiest for your child to eat?

What types are your child's favorite foods?

What foods/type of food does your child refuse?

NON-ORAL FEEDING (only if applicable)

Formula name: Total volume of formula per day:

Formula Concentration (e.g., 20kcal/oz, 24kcal/oz):

Total Volume of Water per Day: Bolus: Continuous:

Feeding Schedule:

How long does it take your child to eat/feed at each meal?

Does your child have difficulty eating certain textures of food? (check all that apply)

☐ Soft foods ☐ Pureed foods ☐ Chewy foods ☐ Crunchy foods

Where does your child eat? (check all that apply)

☐ High chair
☐ Lap
☐ Kitchen table
☐ Couch/floo
☐ Booster seat
☐ Other:_____
☐ Lying down

Does your child indicate to you that he/she is hungry? If yes, check al that apply

☐ Wake up
☐ Says word that mean food
☐ Cries/screams
☐ My child does not act hungry
☐ points

Does your child exhibit any of the following? (check all that apply)

☐ drooling
☐ retching
☐ trouble breathing while eating
☐ gagging
☐ difficulty chewing
☐ difficulty latching on to the nipple
☐ vomiting
☐ difficulty swallowing

Comments:

EDUCATION

Please list the schools, including preschools and early childhood programs, your child has attended.

School	Age/Grade	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL-EMOTIONAL

	Yes	No
Does your child attend to and activity for 10-15 minutes?	☐	☐
Does your child play independently?	☐	☐
Does your child demonstrate frequent mood changes?	☐	☐
Does your child separate from you easily?	☐	☐
Does your child have difficulty changing tasks/activities?	☐	☐
Is your child easy to discipline?	☐	☐
Is your child easily frustrated?	☐	☐
Does your child share toys with others?	☐	☐
Does your child play with other children?	☐	☐

What kinds of toys does your child play with most often?

Does your family have any religious or cultural beliefs that would affect therapy for your child?

Is there any additional information that would help us to better understand your child and/or your concerns?