

# 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: \_\_\_\_\_

### 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: \_\_\_\_\_

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**Hearing:**

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.)?  
\_\_\_\_\_

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: \_\_\_\_\_