Specializing in Pediatric Speech, Language, Feeding, and Swallowing

## School Age History Form

**Today's Date:** ___________________________________

Child's Name: __________________________________________ Date of Birth: ___________________________________

Parents' / Legal Guardians' Names: ___________________________________________________________________
Home Address: ________________________________________________ Home Phone: (_____)_____________________
________________________________________________ Cell Phone: (_____)______________________
County: ________________________________________________________ Work Phone:(_____)______________________
Email Address: ______________________________________________________________________________________
Physical address listed above is for mom / dad / caregiver ____________________________________________________
Can we contact you via text / e-mail regarding your child's therapy schedule and follow-up with therapy appointments?
**Yes No**

Diagnosis(es):_______________________________________________________________________________________
_____________________________________________________________________________________________________

Medical Insurance Company:_____________________________________________________________________________
Policy Number:__________________________________________
Who will be responsible for payments:_______________________________________________________________________
Emergency contact information:
Name:________________________________________________ Relationship:_____________________________________
Phone Number:__________________________________________

Child's Pediatrician:_______________________________________________________________________________________
Address:_________________________________________________________________________________________________
Zip Code:_____________ Phone:_________________________ Fax:___________________________________________________
How long has your child been under this physician's care?:____________________________________________________

Concerns for child/reason for evaluation:

____ Language: The vocabulary your child uses to communicate, the way they order their words in sentences, how they communicate with their peers.
____ Speech: The sounds your child uses in speech.
____ Reading: Sounding out words, reading fluently, answering questions about stories.
____ Written Language: Writing a sentence, paragraph, or full story. Using age appropriate words and punctuation in writing.
____ Spelling: Awareness of sounds that letters make, spelling out words by sounds, manipulating letters/sounds to make new words
____ Following Directions: Following directions without the need for repetition or gesturing/pointing
____ Feeding/Swallowing/Oral Motor: Child is not eating enough foods, is a picky eater, doesn't like certain textures of foods, is a messy eater, has trouble swallowing foods, has oral ties, may not move mouth appropriately when eating.

What do you hope to gain from today's evaluation? ____________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

When did you first notice this problem(s)? ___________________________________________________________________

**Pregnancy, Labor, and Delivery:**

1. List any problems or complications during pregnancy (i.e.: gestational diabetes, eclampsia, maternal seizures, accidents/injuries, etc.):
______________________________________________________________________________________
______________________________________________________________________________________

2. List all medications/drugs taken during pregnancy (i.e.: prenatal vitamins, medications for high blood pressure, medications for seizures, cocaine, heroin, etc.):
______________________________________________________________________________________
______________________________________________________________________________________

3. List any problems or complications during labor and/or delivery (i.e.: cord wrapped around neck, breech delivery, anoxia/"blue" at birth, respiratory distress, induced birth, limpness, stiffness, etc.):
______________________________________________________________________________________
______________________________________________________________________________________

4. Pregnancy: ___ Full Term ___Premature
Length of Gestation:_________________
Length of total labor:________________________________ Difficult labor: __ Yes __No
Delivery Type: __Vaginal __C-section If C-section, what type: __ Emergency __ Planned
Child's birth weight: _____lbs. _____oz.
Elaborate on above delivery complications:_____________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
Length of hospitalization for child:___________________
Complications at birth:
__Jaundice __Cyanosis __Congenital defects __Breathing Difficulties
Other:_________________________________________________________________________________

Was there a need for:
__Oxygen __Transfusions __Tube Feedings
If so, please explain:__________________________________________________________________
______________________________________________________________________________________

Were there any feeding difficulties in infancy: __Yes __No
Explain:_______________________________________________________________________________
______________________________________________________________________________________

5. List any problems complications your child had after birth, as well as any medical conditions/illnesses your child was/has been diagnosed with (e.g.: poor feeder, respiratory distress, seizures, etc.):
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Therapist's Notes:____________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**Developmental and Medical History:**

1. How old was your child when he/she:

Sat alone: __________________ Stood: _____________________ Crawled: ______________________
Walked alone: _______________ Dressed self: ________________ Toileted:_______________________
Babbled: ___________________ Used first words: _____________ Combined words: _______________
Used sentences: _____________ Fed self:_____________________

2. Currently, what is your child's main way he/she communicates?

____Crying/Whining _____2 & 3 word phrases ____ Making noises
____Complete sentences _____Gesturing/Pointing ____Single words
If less than 10 words, please list_______________________________________________

3. Language(s) spoken in the home: ______________________________________________

Does your child speak this language? YES NO
Does your child understand this language? YES NO
Does your child speak English? YES NO
Does your child understand English? YES NO

4. Is your child easily understood by:

**You?** YES NO **Other family members?** YES NO **People outside the home?** YES NO

5. Check all below that your child has a history of:

___ High fevers ___ Ear infections ___ Seizures ___ Mouth breathing ____Frequent colds
___ Hoarseness ___Acid Reflux ___ Swallowing problems ___ Feeding problems
___ Constipation/Diarrhea
___ Allergies: __None __Seasonal __Food __Other
Please list all allergies: _______________________
_______________________
Other:______________________________________________________________

3. Child's general health at present: __Good __Fair __Poor

4. List any accidents / injuries / surgeries / major illnesses / diseases your child has incurred and their dates:

___________________________________ __________
___________________________________ __________
___________________________________ __________
___________________________________ __________

5. List all medications your child currently takes:

| Medication | Dose (i.e.: mg) | Frequency | Reason |
|---|---|---|---|
| _________________ | __________ | ___________ | ________________________________ |
| _________________ | __________ | ___________ | ________________________________ |
| _________________ | __________ | ___________ | ________________________________ |
| _________________ | __________ | ___________ | ________________________________ |

6. Has your child ever had his/hearing tested? YES NO

If YES:
Date:______________________________
Results__________________________________________________________________
Does your child have problems with his/her hearing? If YES, please explain:
_______________________________________________________________________

7. Has your child ever had his/her vision tested? YES NO

If YES:
Date:______________________________
Results__________________________________________________________________
Does your child have problems with his/her hearing? If YES, please explain:
_______________________________________________________________________

8. Has your child had any previous testing? **DATE:** **RESULTS:**

| | | | DATE: | RESULTS: |
|---|---|---|---|---|
| MRI | NO | YES | __________ | ______________________________ |
| CT | NO | YES | __________ | ______________________________ |
| EEG | NO | YES | __________ | ______________________________ |
| Developmental/Educational | NO | YES | __________ | ______________________________ |
| Psychological/Psychiatric | NO | YES | __________ | ______________________________ |
| Neurological | NO | YES | __________ | ______________________________ |

9. Has your child achieved skills and then lost them: __Yes __No
   Explain (what and when):________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

10. Does your child attend school? YES NO
    School Name:________________________________________________________
    Child's grade in school:_______________________________________________

10. Has your child ever been retained? YES NO If yes, which grade?_______________________

11. What is your child's current school placement?
    Regular classroom ESE Gifted Other:__________________________________

    If your child is in an ESE program, please check all that apply:
    ____Full time ____Part time ____Self contained _____Pull Out
    And in what specific type of classroom (LD, EMH, SLI, HI, VE)?______________________

12. List all special education/therapy services your child is **CURRENTLY** receiving (i.e.: speech/language therapy, OT, PT, etc.):

| Service | Provided by(ie: school/private) | Frequency(ie: 2 x week) | Duration(since age 4) |
|---|---|---|---|
| ____________ | ______________ | ____________ | _____________ |
| ____________ | ______________ | ____________ | _____________ |
| ____________ | ______________ | ____________ | _____________ |

13. List all other special education/therapy services your child has **RECEIVED IN THE PAST**, but is no longer receiving (i.e.: speech/language therapy, OT, PT, early intervention, etc.):

| Service | Provided by(ie: school/private) | Frequency(ie: 2 x week) | Duration(since age 4) |
|---|---|---|---|
| ____________ | ______________ | ____________ | _____________ |
| ____________ | ______________ | ____________ | _____________ |
| ____________ | ______________ | ____________ | _____________ |

14. Has your child made progress in previous speech, language, and/or feeding therapy? YES NO
    Please explain: ______________________________________________________
    ______________________________________________________________________

15. How does your child react to his/her difficulties:
    At home?
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________

    In the classroom setting?
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________

Therapist's Notes:______________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**Family Information and History:**

1. Past family history of: (please check) Who?
   - ___Late talking ____________________
   - ___Speech/fluency problems ____________________
   - ___Language problems ____________________
   - ___Cognitive impairment ____________________
   - ___Learning disabilities ____________________
   - ___Dyslexia ____________________
   - ___Psychological/psychiatric problems ____________________
   - ___Neurological problems ____________________
   - ___Autism ____________________
   - ___Genetic disorders ____________________
   - ___Hearing problems ____________________
   - ___Other ____________________

2. Does anyone in your family have a history of food allergies/sensitivities? YES NO
   If yes, please list:____________________
   ____________________

3. List all people living in the home:

| Name | Age | Relationship |
|---|---|---|
| ______ | ___ | ______ |
| ______ | ___ | ______ |
| ______ | ___ | ______ |
| ______ | ___ | ______ |
| ______ | ___ | ______ |

4. Circle parents' level of education:

| | | | | |
|---|---|---|---|---|
| Mother: | Grade school | High school | College | 5+ |
| Father: | Grade school | High school | College | 5+ |

5. Mother's current occupation/job: ____________________
6. Father's current occupation/job: ____________________

**Other:**

Please list any other information you feel is important for us to know:

____________________
____________________
____________________
____________________
____________________
____________________
____________________
____________________

Therapist's Notes:____________________
____________________
____________________
____________________
____________________
____________________
____________________
____________________
____________________
____________________

## General Consent Form:

TheraKids, Inc. may need to contact, or be contacted by, other professionals who have seen or currently see/work with your child. The need for contact may occur due to these needs:

1. Obtaining previous medical or other professional records necessary for evaluation and/or therapy.
2. Discussing your child's evaluation and /or therapy in order to address concerns, recommend additional services, referral to other professionals, and/or to discuss the child's progress.
3. Releasing copies of the evaluation report or progress notes, including documentation to insurance companies.

**I hereby consent to the release of all therapeutic records (including evaluations, daily progress notes, or other documents) to the following:**

Child's Name:________________________________ Child's Date of Birth:_____________________________
Your Name (print):_____________________________ Relation to Child:__________________________________
Your Signature:_______________________________ Date:_____________________________________________
Are you the legal guardian for this child? □ Yes □No If no, name of legal guardian:____________________________

**(Please check each box that applies and print clearly)**

□ Pediatrician Name:______________________________ Group Name:____________________________________
Phone:______________________________ Fax:____________________________________
Address:_____________________________________________________________________

□ Other Doctor Name:______________________________ Specialty:____________________________________
Phone:______________________________ Fax:____________________________________
Address:_____________________________________________________________________
Name of Facility:______________________________________________________________

□ Other Doctor Name:______________________________ Specialty:____________________________________
Phone:______________________________ Fax:____________________________________
Address:_____________________________________________________________________
Name of Facility:______________________________________________________________

□ Therapy Name:______________________________ Specialty:_______________________________
Phone:______________________________ Email:_________________________________
Name of Facility:______________________________________________________________

□ Therapy Name:______________________________ Specialty:_______________________________
Phone:______________________________ Email:_________________________________
Name of Facility:______________________________________________________________

□ Therapy Name:______________________________ Specialty:_______________________________
Phone:______________________________ Email:_________________________________
Name of Facility:______________________________________________________________

□ School Name of School:______________________ Teacher/Therapist Name:___________________
Phone:______________________________ Fax:____________________________________
Address:_____________________________________________________________________

□ Family Members Name:______________________________ Relation to Child:_________________________
Phone:______________________________ Email:_________________________________
Address:_____________________________________________________________________

Name:______________________________ Relation to Child:_________________________
Phone:______________________________ Email:_________________________________
Address:_____________________________________________________________________

## Appointment and Daily Schedule Form

Child's Name:__________________________________________ Date of Birth____________________
Your Name:____________________________________________ Relation to Child:________________

Today your child is being assessed to determine/rule-out his/her need for therapy. If your child does qualify for therapy, we will need to arrange days and times with you that would be optimal for your child to attend therapy. Although it is not always possible for us to meet these exact days and times, we do try our best to accommodate your preferences.

Below, please list **ALL** days and hours (Monday-Friday) that your child is available. Please make sure to fill this out accurately taking into account any time your child may be in school or other therapies, and may have tutoring or sports.

Day:_________________________ Times Available:_________________________________________
Day:_________________________ Times Available:_________________________________________
Day:_________________________ Times Available:_________________________________________
Day:_________________________ Times Available:_________________________________________
Day:_________________________ Times Available:_________________________________________

---

## HIPAA – Notice of Privacy Practices

**Along with this history form you were given a sheet with information regarding out privacy practices. Please fill out and sign below as confirmation that you were given this information.**

**I, (print name)________________________________________________, have received and read the following documents, and they were explained to me, as needed:** ***Notice of Privacy Practices, as required by HIPAA; Letter of introduction to TheraKids, Inc.***

_________________________________________________ ____________________________
**Signature/Relation to patient** **Date**

**THANK YOU FOR YOUR CAREFUL ATTENTION TO THIS FORM.**
**This confidential information will be used to assist us in the evaluation of your child.**