Patient Information

Baptist Medical Center East
Therapy Center
Physical/Occupational/Speech Therapy
Adult, Pediatric, Infant, Neonatal
400 Taylor Road, Montgomery, AL 36117
Phone: 334-244-8345
Fax: 334-213-6262

STATEMENT OF THE PROBLEM:

Reason for Visit:

❑ Language Concerns ❑ Stuttering ❑ Articulation ❑ Voice ❑ Other______

When was it first noticed and by whom?______

What is the reaction of the child to the problem?______

What is the reaction of parents and others to the problem?______

Do other members of the family (parents, aunts, uncles, or grandparents) have a similar problem?______

______

GENERAL INFORMATION:

What languages are used in the home? ❑ English ❑ Spanish ❑ Other______

Is your child, or has your child ever been allergic to latex? ❑ Yes ❑ No

Other allergies:______

Is your child exhibiting pain today? ❑ Yes ❑ No

If yes, please rate the level of pain: ❑ 0 (no pain) ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 (hurts as much as you can imagine)

How does your child express pain? ❑ Crying ❑ Verbal ❑ Other______

How do you comfort your child? ❑ Rocking ❑ Holding ❑ Other______

MEDICAL HISTORY:

Was the pregnancy full-term (9 months)? ❑ Yes ❑ No If not, how premature?______

Why was pregnancy shortened?______ Child's birth weight:______

Were alcohol and/or illegal drugs used during pregnancy? ❑ Yes ❑ No Specify:______

Delivery: ❑ Vaginal ❑ Cesarean

Were there complications at birth? ❑ The baby was blue ❑ The umbilical cord was wrapped around neck

❑ Meconium aspiration ❑ Baby required oxygen ❑ Other (explain)______

Were there problems in the postnatal period (first two weeks)? ❑ Yes ❑ No Please specify______

______

Check any of the following illnesses or operations that your child may have had:

❑ Adenoidectomy/Tonsillectomy Date:______ ❑ Convulsions/Seizures Date:______

❑ Head injury Date:______ ❑ Surgeries If so, for what?______ Date:______

❑ Other______ Date:______

Has hearing been tested? ❑ Yes ❑ No If so, when?______ By whom?______

Results:______

Do you think your child has a hearing problem? ❑ Yes ❑ No If so, what makes you think this?______

______

Has your child had ear infections? ❑ Yes ❑ No If so, when did the last one occur?______

Has the child had tubes? ❑ Yes ❑ No If so, when?______ By whom?______

Treated with medications? ❑ Yes ❑ No Multiple sets? ❑ Yes ❑ No

Is your child receiving treatment for any disorder? ❑ Yes ❑ No Describe:______

Is your child taking any prescription medications? ❑ Yes ❑ No If so, why?______

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SPEECH AND HEARING HISTORY

Did your child make normal baby sounds (babbling) during the first six months? ❑ Yes ❑ No

How old was your child when he/she said their first real word?______________________________

How old was your child when he/she began putting words together in phrases?______________________________

Approximately how many words does your child say now? ❑ Under 25 ❑ 25-75 ❑ Over 75

Has your child ever had more speech than he/she has now? ❑ Yes ❑ No

My child currently: ❑ Doesn't try to communicate ❑ Uses words and a few phrases ❑ Uses gestures(pointing, etc.)

❑ Uses complete sentences ❑ Uses gestures and a few words

How well is your child' speech understood by you? ❑ Usually understood by immediate family

❑ Not generally understood by anyone other than the mother/primary caregiver

❑ Understood approximately 50% of the time by people outside the family ❑ Other (explain)______________________________

Does your child turn to his/her name? ❑ Yes ❑ No

Does your child understand and follow simple commands such as "Get me the ball"? ❑ Yes ❑ No

Has your child ever seen a speech/language pathologist? ❑ Yes ❑ No If so, when?______________________________

SOCIAL/EDUCATIONAL HISTORY

Patient lives at home with (please list all family members in household):______________________________

____

Is your child currently enrolled in a daycare or preschool program? ❑ Yes ❑ No

Number of days per week:_____ Age group:_____ How long has he/she attended?______________________________

Where does your child presently attend school:______________________________ Grade:____________

Does your child receive resource services? ❑ Yes ❑ No Describe:______________________________

Classroom teacher has the following concerns:

❑ None ❑ Difficulty communicating ❑ Decreased attention span ❑ Difficulty following direction

❑ Aggressive behavior ❑ Lack of ability to communicate ❑ Decreased social interaction

❑ Other (describe):______________________________

DAILY BEHAVIOR:

Regarding behavior, my child:

❑ Interacts better with adults than with peers ❑ Interacts well with children and adults ❑ Is easy to discipline

❑ Has difficulty paying attention ❑ Is difficult to discipline

Regarding sleeping patterns, my child:

❑ Sleeps all night ❑ Sleeps with parents ❑ Does not sleep well ❑ Other (explain):______________________________

Regarding play activity, my child:

❑ Plays well with peers ❑ Prefers to play alone ❑ Acts differently than other children

Describe:______________________________

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MOTOR DEVELOPMENT:

How old was the child when he/she"

Sat alone:____ Crawled:_____________________________________

Walked unaided:___________________________________ Maintained bowel and bladder control:________________________

Does your child appear awkward or uncoordinated? ❑ Yes ❑ No If so,why?____

Do you have any concerns about your child's feeding? ❑ Yes ❑ No Explain:____

Does your child drool excessively? ❑ Yes ❑ No

Does your child choke/cough during feeding? ❑ Yes ❑ No

Does your child exhibit returned food through his/her nose? ❑ Yes ❑ No

Has your child ever had a swallow study? ❑ Yes ❑ No

Check foods that best describe your child's diet:

❑ Primarily formula or milk ❑ Baby food ❑ Soft solids ❑ Regular diet ❑ Limited food choices

____ ______________________________ ________________________

Signature of Person Completing Questionnaire Relationship to Child Date

If you have any concerns that have not been addressed in this questionnaire, you may record them on the back of this form.