JABBERDOGS
SPEECH THERAPY

Stephanie Masek MS, CCC-SLP
1898 Santa Rosa Ave
Pasadena, CA 91104
P. 626.824.1204
Stephanie@jabberdogs.com

MEDICAL HISTORY FORM

Please state in your own words what you think the child's problem is, and what 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?

_____

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 children 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 words/ words are clearer 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. ****