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## MEDICAL HISTORY FORM

Child's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In your own words, what is the child's difficulty, and what do you think may have caused it?

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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? Has your child been seen by an OT and/or PT?

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Are there any legal issues (i.e. custody arrangements) relevant to your child's treatment?

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Does your child have any behavioral health concerns that we should be aware of?

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Are there cultural or spiritual considerations that may impact your child's treatment?

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Do you or your child need interpreter / language assistance services? If so, for what language?

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### **Prenatal/Birth History**

Please check all that apply

- ☐ Normal pregnancy and birth   ☐ Full term   If not, 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)
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### **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/colic   ☐ recurrent/serious illnesses   ☐ operations/surgeries
- ☐ accidents/physical injuries   ☐ vision problems   ☐ hearing difficulty   ☐ audible breathing
- ☐ open mouth posture   ☐ mouth breathing   ☐ chronic congestion   ☐ sinus infections
- ☐ mouth objects/fingers/clothing etc.

☐ other \_\_\_\_\_ ☐ allergies \_\_\_\_\_

Has your child had ear infections? List frequency and severity. Were antibiotics effective in treating the problem?

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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?

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### **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 child 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: \_\_\_\_\_

made wants known: \_\_\_\_\_ ate pureed fruits/veggies: \_\_\_\_\_

ate pureed meats: \_\_\_\_\_ ate 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 sounds or words more clearly 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?

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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)?

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Please check any 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?

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Does your child have any academic difficulties?

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Did your child's speech/language development seem to develop normally and then stop or regress?

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Does your child often hesitate and/or repeat sounds/words?

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Is your child's speech too fast \_\_\_\_\_, too slow \_\_\_\_\_, or average \_\_\_\_\_?

Is your child's voice too soft \_\_\_\_\_, too loud \_\_\_\_\_, average volume \_\_\_\_\_, hoarse \_\_\_\_\_, nasal \_\_\_\_\_, other \_\_\_\_\_?

### **School History**

<b>Educational Setting</b>	<b>Location/School</b>	<b>Teacher</b>	<b>Special Services</b>
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. \*\***