Child History Form

Date _____

Child's Name _____ Date of Birth _____

Address _____

City _____ State ___ Zip _____ Phone _____

Sex _____ Race _____ Age _____ Grade _____ School _____

Pediatrician _____

Father's Name _____ Date of Birth _____

Address _____ Race _____

City _____ State ___ Zip _____ Phone _____

Employer _____ Work _____

Employer Address _____ Email _____

Mother's Name _____ Date of Birth _____

Address _____ Race _____

City _____ State ___ Zip _____ Phone _____

Employer _____ Work _____

Employer Address _____ Email _____

Insurance

Primary _____ ID # _____

Secondary _____ ID # _____

321 THERAPY
Pediatric Speech Language Therapy
3040 N. Wickham Rd, Suite 4, Melbourne, FL 32935
(321**) 751-1443** tel | (321) **751-1448** fax | **321therapy.life**

Birth History | Circle all that apply

Adopted Full-Term Pre-Term at ____ weeks

Vaginal C-Section Breech Vacuum Extraction Fetal Distress Required Oxygen

Admitted NICU for how long? _____ Explain/Other _____

Brothers/Sisters Age/Grade

_____ _____

_____ _____

_____ _____

Health History | Has your child had…

Frequent colds, fevers? _____ Asthma or Allergies? _____

Allergies to?_____

Ear Infections? _____ How Many? _____ Age first time? _____

Hearing Tested? _____ When/Where? _____ Results? _____

Diagnosed ADHD/ADD? _____ Diagnosed LD? _____

Psychological Evaluation? _ When? _____ Where? _____

Other Health problems, Surgeries, or Hospitalizations? _____

_____

Current Medications? _____

_____

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Developmental History | List age when child first…

Sat alone _____ Crawled _____ Walked _____

Ate Stage I Foods _____ Stage III _____ Table Foods _____

First Words _____ Weaned to Cup _____ Gave Up Bottle _____

Gave Up Pacifier _____ Started "Spouted" Cups _____

List other developmental delays _____

_____

_____

Does your child receive any special services in school? _____ List _____

_____

Concerns

What concerns have brought you to this evaluation/treatment? _____

_____

_____

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