TERREBONNE GENERAL MEDICAL CENTER
OUTPATIENT THERAPY
HISTORY FORM

GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____

Mother's Name: _____ Phone (home/work)_____
_____

Father's Name: _____

Referred by: _____

Pediatrician or Family Doctor: _____

Describe the child's problem:

When was the problem first noticed? By whom?

What do you think may have caused the problem?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does she or he feel about it?

Are there any other physical, speech, language, or hearing conditions in your family? If yes, please describe.

How does the child usually communicate (gestures, single words, short phrases, sentences)?

PRENATAL AND BIRTH HISTORY

Mother's general health during pregnancy (illnesses, accidents, medications, etc.)

Length of pregnancy: _____ Length of labor:_____

General condition: _____ Birth weight: _____

Circle type of delivery: head first feet first breech Cesarean

Were there any unusual conditions that may have affected the pregnancy or birth?

MEDICAL HISTORY

Provide the appropriate ages at which the child suffered the following illness or conditions:

Allergies _____	**Asthma _____**	**Chicken Pox _____**
Colds _____	**Convulsions _____**	**Croup _____**
Dizziness _____	**Ear infections _____**	**Encephalitis _____**
Headaches _____	**High Fever _____**	**Influenza _____**
Meningitis _____	**Pneumonia _____**	**Seizures _____**
Sinusitis/tonsillitis _____	**Other _____**	

Has the child had any surgeries? If yes, what type and when?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify.

DEVELOPMENTAL HISTORY

Provide the approximate age at which the child began to do the following activities:

Crawl_____ Sit _____ Stand _____

Walk _____ Feed self _____ Dress self _____

Use toilet _____

(For Speech Therapy only answer the next 5*(starred) items)

*** Use single words (e.g., no, mom, doggie, etc.): _____**

_____

*** Combine words (e.g., me go, daddy shoe, etc.) _____**

_____

*** Name simple objects (e.g., dog, car, tree, etc.)_____**

_____

*** Use simple questions (e.g., Where's doggie? Etc.) _____**

_____

***Engage in a conversation_____**

_____

Does the child have difficulty walking, running, or participating in any other activities which requires muscle coordination?

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)? If yes, describe.

Describe child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.)

EDUCATIONAL HISTORY

School:_____ Grade: _____

Teacher(s): _____

How is the child doing academically (or preacademically)?

Does the child receive special services? If yes, describe.

How does the child interact with others (e.g., shy, aggressive, uncooperative, etc)?

Provide additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form:_____
Relationship to child: _____
Signed:_____Date:_____