the **Learning** Fountain, Inc.

...where therapy is fun & children are nurtured to grow & blossom...

NEW PATIENT HEALTH HISTORY

DEMOGRAPHIC and FAMILY INFORMATION

Today's Date: _________

1. **Child's Name**:____
2. **Birthdate:**____
3. **Gender**: ____
4. **Parent/s Name/s**:____
5. **Cell/ Daytime Phone**: ____
6. **Email**: ____
7. **Primary Care/ Pediatrician:** _________________________________**Office number**:_________________
8. **Primary diagnosis:**____
9. **Child lives with** (check one):

[ ] Birth Parents [ ] Foster Parents [ ] One Parent [ ] Adoptive Parents [ ] Parent and Step-Parent

[ ] Other: Please Explain: ____

10. **Are there other children in the family**? Please list:

Name	Age	Gender	Grade	Regulatory/Feeding/Speech/Hearing Problems?

PLEASE PROVIDE A COPY OF YOUR CHILD'S CURRENT IMMUNIZATION RECORDS

Immunizations NOT given for any reason will require a waiver certificate signature form to be completed by parent or legal guardian.

***For office use only*- Records received, date:** _______________

HEALTH HISTORY

11. **History of Pregnancy**: [ ]Unremarkable (No Complications) [ ]Remarkable due to: _________________
12. **Medications taken during pregnancy**:____
13. **Delivery**: [ ]Normal Vaginal Delivery [ ]C-Section [ ]Full Term [ ]Premature: Gestational Age #___weeks
14. **Hospital Name and Location:** ____
15. **Days in Hospital**: __________________________________**Days in NICU**: ___________________________
16. **Birth Size - Weight**: _______________________ **Length**: ____
17. **Breathing Difficulties**: Yes / No Treatment: ____
18. **Jaundice**: Yes / No Treatment: ____

ILLNESSES/ALLERGIES

19. **Illnesses that required hospital stay, list**: ____

20. **Has your child had an ear infection? # of incidents____ Name of Medication:**_______________________

21. **Allergies Yes / No if yes, please list**:____

____

***ANAPHALYSIS RISK*? Yes / No DOES THIS CHILD CARRY AN EPIPEN? Yes / No**

CURRENT MEDICATIONS - INCLUDING SUPPLEMENTS

22. **Please list all medications your child takes and why: ______**____

____

____

DEVELOPMENTAL HISTORY

23. **Physical Milestones**: [ ] Typical [ ] Delayed

Physical Milestone	Rolled Over	Sat Alone	Crawled	Walked	Ran	Climbs Stairs	Jumps
Age Achieved (in months)							

24. **Language Milestones** [ ] Typical [ ] Delayed

Language Milestone	Babbled	Jargon	First Words	Put 2 Words Together	Spoke in Short Sentences
Age Achieved (in months)					

25. **How many hours does your child sleep? _______ Difficulty falling asleep? Y / N**

26. **Describe the bedtime routine**____

____

FEEDING/EATING

27. **Was your child breastfed**? Y / N If so, how long?____

28. **Was your child fed formula**? Y / N **Bottle still required**? Y / N

29. **At what age did the child take solid food**? ____

30. **What type of foods can your child eat** (i.e puree, soft foods)____

31. **Does your child eat a varied, balanced diet**? Y / N

FEEDING/EATING cont.

32. **Does your child have feeding difficulties** Y/ N If yes, explain____
33. **History of Reflux, explain**:____
34. **Has your child ever had a swallow study? Y/ N** If so, date of study: ________________________________
35. **Does you have any concerns regarding the child's ability to eat?** _____________________________________
36. **Does your child…**

Put toys/objects in his/her mouth?	Use a pacifier or suck thumb/fingers?	Brush his/her teeth or allow brushing	Choke on food or liquids?	Have difficulty with certain textures of food?

BEHAVIORAL CHARACTERISTICS

37. **Describe your child's temperament as an infant:**

____

38. **Describe your child's temperament as a toddler:**

____

39. **Describe your child's temperament within the past 3 months:**

____

40. **Please check all behaviors/characteristics that describe your child:**

[ ] Cooperative [ ] Plays alone for reasonable length of time [ ] Attentive [ ] Willing to try new activities

[ ] Stubborn [ ] Easily distracted/Short attention [ ] Destructive/Aggressive [ ] Easily frustrated/Impulsive

[ ] Self-abusive behavior [ ] Restless [ ] Separation difficulties [ ] Withdrawn [ ] Inappropriate behavior

[ ] Perfectionist / Insist on sameness [ ] Tics/Repetitive behavior [ ] Poor eye contact

41. **Has your child ever become violent with you? Yes / No Someone else? Yes / No**

THERAPY HISTORY- OT/ PT/ ST/ Psychological

42. **Has your child received any other type of evaluation or therapy (PT, OT, counseling, etc.)?** Yes / No

If yes, please describe: ____

Name of clinic or practitioner/s:

____

Additional Concerns or Comments:

____

____

NEW PATIENT HEALTH HISTORY

SPEECH-LANGUAGE-HEARING HISTORY

Is there a family history of speech or language issues? Yes / No
If yes, explain:____
Do you feel the child has a speech problem? Yes / No
If yes, please describe: ____
Has he/she ever had a speech evaluation/screening? Y / N If yes, where and when?___________________
What were you told? ____
Has the child ever had speech therapy? Y / N If yes, where and when?_______________________________
What was/is he/she working on? ____
Has the child ever lost speech that he/she had previously learned? Yes No
If yes, please describe ____
Do you feel the child has a hearing problem? Yes No
If yes, describe____
Has he/she ever had a hearing evaluation/screening? Yes No
If yes, what were you told? ____

CURRENT SPEECH/ LANGUAGE/ HEARING

Does the child...
[ ] "Get stuck" Repeat sounds, words or phrases over and over? [ ] Understand what *YOU* are saying?
[ ] Is the child difficult to understand? [ ] Retrieve or point to common objects upon request (ball, cup, shoe)?
[ ] Follow simple directions ("Shut the door" or "Get your shoes") [ ] Respond correctly to yes/no questions?
Does the child respond correctly to who/what/where/when/why questions? Yes / No
The child currently communicates using...
[ ] Body language [ ] Sounds (vowels, grunting) [ ] Words (shoe, doggy, up) [ ] 2 to 4 word sentences
[ ] Speak in sentences longer than four words
[ ] Other, please describe: ___________________________________

LANGUAGES SPOKEN AT HOME

Is there a language other than English spoken in the home? Yes / No (if no skip to next section)
If yes, which language/s? ____
Does the child speak the language? Yes / No Does the child understand the language? Yes / No
Who speaks the language, please list? ____
Which language does the child *prefer* to speak at home? ____

Additional Concerns or Comments:

____

____