STEPPING STONE
KIDS THERAPY

Patient Name: _____

Speech Therapy Patient History

Pregnancy/ Birth History:

Pregnancy complications: yes no if yes, explain:

_____

Full term: Yes No How many weeks? _____

Delivery type: C-section/vaginal

Birth Weight:_____ pounds _____ ounces

Complications with delivery: (i.e. NICU stay, length of stay, breathing complications etc.)
Please explain:

_____

_____

History of surgery, major illnesses or hospitalizations: Please include length of hospitalization, complications, and surgeries and dates:

_____

Pediatrician Name:_____ Primary Language spoken at home: _____

Allergies: yes___ no___ if yes, to what: _____

Last hearing test: Date: _____ Results? pass/fail _____

Vision concerns: yes no Wears glasses: yes no

Explain: _____

Medications: yes no
Please list Medications:_____

_____

Specialists: (i.e. neuro, developmental pediatrician, cardio, ENT, psychologist, pulmonologist, allergist, ophthalmologist, etc.)

_____

_____

What is your main reason for seeking therapy?

_____

_____

Socialization:

Siblings: Brother(s): yes/no Age(s): _____
Sister(s): yes/no Age(s): _____

Attends daycare: yes/no if yes, Name: _____

Participate in Early Steps: yes/no if yes, Name of Therapist/frequency of visits
_____

Attends school: yes/no if yes, Name: _____ Grade: _____
Does the child have an IEP: yes/no if yes, Please provide office a copy.

Play groups/opportunities for socialization: (i.e. library/story time, play group, gymnastics, sports, etc.)
_____

Prior/current therapy:
Speech therapy: yes/no if yes, Name of Provider_____

Occupational therapy: yes/no if yes, Name of Provider: _____

ABA therapy: yes/no if yes, Name of Provider: _____

Feeding skills:
Uses fork/spoon ____ Finger feeds:____ Refuses to touch food:____

Currently drinks from:
Bottle ____ Sippy cup ____ Straw ____ Open mouth cup ____

Tolerates Tooth brushing: yes _____ no _____ Tolerates hand washing: yes _____ no _____

Tolerates textures: yes ____ no _____

Difficulty with textures: **wet** yes/no **slimy** yes/no **mushy** yes/no **sand** yes/no

clothing tags yes/no **grass** yes/no **dirty/or dirt** yes/no

Special Diet: explain (i.e. gluten, soy, milk free) _____
Feeding/food preferences:
Eats regular diet: Yes No **Picky diet:** Yes No

Preferences: Yes No **Likes food textures (i.e. crunchy, soft, chewy, mushy)**: Yes No

Explain (i.e, what will or will not eat list , etc.):
_____

_____

_____

_____

Language/Communication:

What sounds do you currently hear when they verbalize/make sounds: (i.e. pa, ma, da, ba, h, wha, ta, da, vowels e, o, etc.) please list:
_____

Approximately how many words are in his/her repertoire currently: _____

Does your child combine words:
2 word phrases (ie. “go car”, “eat more,” “More play”) : yes ____ no____
3 word sentences (I want more, I need help): yes _____ no ____
Repetitive phrases: yes _____ no___
Jargon (nonspeech sounds/words): yes _____ no_____
Answer simple wh-questions: yes _____ no_____

How often can you understand what your child is saying/requesting? % of time _____
Do others have difficulty understanding what your child is saying? Yes ___ No____

Does your child Follow Directions:
Familiar commands: “Give me a kiss, high five, come here”: yes____ no_____ sometimes ___
1 step: “Go get your shoes” “get a snack” Yes ___ No ____ Sometimes _____
2-Step: “Get your shoes and bring them to me.” Yes ____ No ____ Sometimes ____

Respond when you call their name? Yes ____ no___
Demonstrate eye contact: yes____ no ____

Sits and reads a book: Yes No **Just flips pages:**Yes No **Looks at pictures in book:**Yes No

Sits and plays with a toy: Yes No **5 min:** Yes No **10 min:** Yes No **15 min:** Yes No

Play with other children: yes no **Play independently:** yes no **Share toys:** yes no

Participate in pretend play: yes no **Play with another child with the same toy:** yes no

Play next to another child but with separate toys: yes no

Watches a TV show: Yes No **15 min**: Yes No **30 min:** Yes No

Do they get frustrated? Yes No Why?_____

_____

What do they do when they are frustrated? (I.e. Cry, throw self on the floor, Screams, tantrums, Hits/Bites) Explain:_____

_____

How does your child currently communicate with you at home? (i.e. tell you what they want/need) Examples: (Point, bring you item, bring you to the item, use sounds, gesture, anticipate their needs and they do not communicate) Explain:_____

_____

What is your biggest concern regarding language and/or speech to address for the next six months?

_____

_____

_____