Speech and Language Therapy Addendum

Today's Date: ____________
Child's Name: ______________________________ Birth Date: ______________ Age: _______
Sex: ☐ Male ☐ Female
Father's Name: ____________________ Mother's Name: ____________________________
Name and relationship of person filling out this form: __________________________________

PLEASE CHECK AND FILL IN

Birth History (For children only)
Duration of pregnancy ________ Birth weight __________ ☐ Natural ☐ C-Section
Problems during pregnancy? ☐ Yes ☐ No (describe) ________________________________
Problems during delivery? ☐ Yes ☐ No (describe) ________________________________
Problems after birth? ☐ Yes ☐ No (describe) ________________________________

MEDICAL HISTORY

Current Health: ☐ Healthy ☐ Has been ill with: ________________________________
Hospitalizations: ☐ Yes ☐ No ________________________________
Allergies: ☐ Yes ☐ No ________________________________
Seizures: ☐ Yes ☐ No Current Medication: ________________________________
Has your child had a tonsillectomy or adenoidectomy ☐ Yes ☐ No When ______________
Has your child had any earaches/ear infections? ☐ Yes ☐ No How many? _____ PE tubes ☐ Yes ☐ No
Has your child had his/her hearing tested? ☐ Yes ☐ No When? __________ Results: ______________
Other: ________________________________

DEVELOPMENTAL HISTORY (For children only)

Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed).

Sat up alone __________	Crawled ___________	Walked ___________
Dressed self __________	Tied shoes___________	Fed Self ___________
Weaned from bottle/beast ________	First Words_________	Combined words________

Makes wants/needs known? ☐ Yes ☐ No How? ________________________________
Primary Language spoken in the home: ____________ If other than English, does the client understand and speak this language and how well? ☐ Yes ☐ No ________________________________
Any speech or hearing problems in the family? ☐ Yes ☐ No ________________________________
Does your child have difficulty following directions? ☐ Yes ☐ No ________________________________
How many words can your child say? ________________________________

Do you understand everything your child says? ☐ Yes ☐ No If "No", how much do you understand?
☐ Nothing ☐ Almost Nothing ☐ About Half of what they say ☐ Most of what they say
Do unfamiliar people understand everything your child says? ☐ Yes ☐ No If "No", how much?
☐ Nothing ☐ Almost Nothing ☐ About Half of what they say ☐ Most of what they say
Describe what it is like to have a conversation with your child: ________________________________
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DOES YOUR CHILD HAVE:

Vision problems: ☐ Yes ☐ No Treatment: ______________________

Hearing difficulties: ☐ Yes ☐ No Treatment: ______________________

Dental problems: ☐ Yes ☐ No Treatment: ______________________

Does your child:

Suck his/her thumb? ☐ Yes ☐ No use a pacifier? ☐ Yes ☐ No use a bottle ☐ Yes ☐ No

EDUCATIONAL HISTORY (For school-age children only)

Name of School ______________________ City ______________________ Grade ________

Has student repeated any grades? ☐ No ☐ Yes, grade ____________

Is student experiencing problems in school? ☐ Yes ☐ No ______________________

Is student enrolled in special education classes? ☐ Yes ☐ No ______________________

Is student receiving special tutoring for any subject? ☐ Yes ☐ No ______________________

Is student receiving speech therapy now or has in the past? ☐ Yes ☐ No How often? ______________

Is student receiving any other type of therapy? ☐ Yes ☐ No What type? ______________________

FEEDING HISTORY

Check if your child has any difficulties with the following?

☐ Swallowing ☐ Blowing ☐ Drinking ☐ Drooling excessively

☐ Chewing ☐ Using a spoon independently

Dinking from: ☐ a straw ☐ from a cup

Favorite foods: ______________________

Aversive foods: (if any) ______________________

BEHAVIOR (Please check the ones that describe the child)

Communication: ☐ Quiet ☐ Sometimes talks ☐ Very talkative

Social Skills: ☐ Interacts with everyone including strangers ☐ Withdrawn

☐ Shy around strangers ☐ Does not get along with peers ☐ Aggressive

Attention: ☐ Very good ☐ Adequate ☐ Somewhat poor ☐ Poor

PLAY (For young children only)

☐ Puts most toys in mouth

☐ Activates simple cause & effect toys

☐ Not interested in toys (mostly throws them)

☐ Explores toys by banging/shaking

☐ Engages in pretend play (feeds dolls)

☐ Enjoys playing with toys but needs help

What motivates your child the most? ______________________

What discipline method works best? ______________________

Any additional comments? ______________________

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