JANINE STIENE SPEECH LANGUAGE PATHOLOGY, P.C.

Main Phone: 631-689-6858 Fax: 631-751-6027

Patient Name: _____ **Date of Birth:** _____

Child lives with (check one):					
Birth Parents		Foster Parents		Family Member: _____	
Adoptive Parents		One Parent		Other:_____	

Prenatal History			
Duration of Pregnancy:	Length of Delivery:		Type of Delivery:
Any trauma, illness, condition, or accident during pregnancy or delivery? (if yes, explain):			
Any loss of oxygen to child during delivery? (if yes, how long):			

Immediately Following Birth	**Y/N**
Blueish appearance	
Bruising	
Jaundice appearance	
Spent time in NICU	
Difficulty latching	
Difficulty sucking	
Difficulty swallowing	
Consult with lactation specialist	
Difficulty with lactose formula	
Gassy	
Colic	
Spit up often	
Reflux	
Trialed a variety of formulas	
Trialed a variety of bottle types	
Trialed a variety of nipple types	
Trialed a variety of pacifier types	
Swallowed meconium	
Needed to be aspirated	

Developmental History	**Early**	**Average**	**Late**	**Never**
Hold head up				
Roll over				
Sit up (no support)				
Crawl				
Walk unaided				
Babble				
Speak 1st Work				
Use sentences				

Feeding History	**Y/N**	**Age Started / Discontinued**
Breast Fed		
Bottle Fed		
Difficulties with baby cereal		
Difficulties with baby food		
Difficulties with Stage 1 foods		
Difficulties with Stage 2 foods		
Difficulties with Stage 3 foods		
Difficulties with finger foods		
Texture/consistency aversion		

Oral Motor/Motor Planning Skills	**Y/N**
Do you notice saliva on the pillowcase?	
Do you notice saliva while awake?	
Do you notice saliva while speaking?	
Do you notice saliva while eating?	

Family History	
Has anyone in the family ever:	**Y/N**
Received speech therapy	
Received myofunctional therapy	
Had braces	
Has palate expander	
Suffered from TMJ or TMJ symptoms	
Suffered from sleep apnea	

Does your child:	**Y/N**	**Does your child:**	**Y/N**
Eat steak		Eat chewy foods	
Eat yogurt with pieces		Eat slow	
Eat sandwiches		Drink excessively at meals	
Eat soup		Over stuff	
Eat pasta sauce		Gag easily	
Eat condiments		Chew excessively	
Eat mashed potatoes		Spit out food	
Eat apple sauce		Ever choke	
Eat deli meat			
Eat eggs			
Eat hard foods			
Eat soft foods			
Eat crunchy foods			

JANINE STIENE SPEECH LANGUAGE PATHOLOGY, P.C.

Main Phone: 631-689-6858 Fax: 631-751-6027

Background History						
Problem	**Y/N**	**How often/when/why:**	**Does your child:**	**Currently**	**Past**	**Never**
Ear infections			Grind their teeth			
Myringotomy tubes			Clench their teeth			
Strep throat			Have TMJ pain			
Tonsillitis			Snore			
Tonsillectomy			Move around a lot while asleep			
Adenoidectomy			Suck their thumb			
Bronchitis			Suck their finger			
Pneumonia			Suck their tongue			
Croup			Suck on their shirt			
Asthma			Lick their lips			
Use a nebulizer			Bite their lips			
Sinus infections			Have chapped lips			
Allergies						

Is there any additional information which you feel would better help us to understand your child? _____

_____

Did your child ever receive early intervention, preschool, or special education services to support their development? (please explain)_____

Does your child seem to have any difficulty understanding speech sounds: (If yes, explain) _____

_____

At what age did your child start school?_____ Were any grades repeated?_____

Are there any school subjects which they have particular difficulties?_____

How does your child get along with others?_____

Other Examinations

Has your child ever has a speech/language/processing evaluation or therapy prior to this time?_____

If yes, when and where? _____ Would you mind sharing these results?_____

Has your child ever received a full audiological evaluation? _____ If yes, when?_____

Why was it recommended and would you share the results?_____

Has your child ever has a full neurological and/or physical evaluation?_____ If yes, when?_____

Who performed the evaluation and why and would you share the results?_____

_____

Motor Function

Does your child have any sensitivity to different textures on their hands/feet/face/other body parts? _____

If yes, please explain._____

Does your child have any difficulties manipulation their body in space? If yes, please explain._____

Does your child have any difficulty manipulating small objects with their hands?_____

Does your child appear to have an awkward gait? _____

Does your child use their hands/eyes for anything other than their typical functions? (flapping, starting, biting)_____