Stony Brook Medicine

CHILD/ADOLESCENT (6-17 YEARS)
SPEECH-LANGUAGE PATHOLOGY HISTORY FORM

Name: ______________________________
Date of Birth: __________________________

Person completing form: □Patient □Spouse □Parent/Guardian □Other-Name__________________________
Address: ____
Telephone: (home) ______________________(work) ____________________(cell) ____________________________
Email: ____
Physician Name: ____ Physician Phone: ______________________
Referred by: ____
Reason for evaluation: ____
Insurance: ____ Referral Needed: □yes □no
Policy Number: ____

Results will be sent to names/locations listed below if address or faxes are provided

Name Address or Fax Phone

____
____
____
____

Disclosure of healthcare information will only be provided is authorized by the patient or legal guardian except for known healthcare providers

____
Name Relationship to patient Address Phone Fax

____
Name Relationship to patient Address Phone Fax

I authorize the department to disclose healthcare information to names above. Valid for one year.
Signature of □ Patient □Parent/Guardian ____ Date: ___________
Printed name of Parent/Guardian: ____

Past Medical History

Condition			Condition		
ADD/ADHD	□YES	□NO	HIV Positive	□YES	□NO
AIDS	□YES	□NO	Allergies	□YES	□NO
Laryngitis	□YES	□ NO	Asthma	□YES	□NO
Learning Disability	□YES	□NO	Chicken Pox	□YES	□NO
Mental Retardation	□YES	□NO	Cancer________	□YES	□NO
Physical Limitations	□YES	□NO	Cerebral Palsy	□YES	□NO
Pneumonia/Bronchitis	□YES	□NO	Developmental Delays	□YES	□NO
Respiratory Disease	□YES	□NO	Diabetes	□YES	□NO
Shortness of breath	□YES	□NO	Ear Infections	□YES	□NO
Seizures	□YES	□NO	Epilepsy	□YES	□NO
Sinus Problems	□YES	□NO	Gastric Reflux	□YES	□NO
Speech/Lang Impairment	□YES	□NO	Head Injury	□YES	□NO
Hearing Loss	□YES	□NO	Swallowing Problems	□YES	□NO
Heart Problems	□YES	□NO	Tracheostomy tube	□YES	□NO
Ventilator Dependency	□YES	□NO	High fevers	□YES	□NO
Visual Impairment	□YES	□NO	Voice Impairment	□YES	□NO
Stroke	□YES	□NO	Brain Tumor	□YES	□NO

Comments/Other Medical History: ____
____
____

Speech Pathologist's notes: ____
____
____

 Name: ______________________________

Please list any surgeries/medications (and reason for medication): ____
____

Significant Family medical history: ____
____

Have you ever been examined or treated by the following?

			Name/Findings
Ear Nose and Throat Specialist	☐YES	☐NO	___________________________
Eye Specialist	☐YES	☐NO	___________________________
Neurologist	☐YES	☐NO	___________________________
Psychiatrist/Psychologist	☐YES	☐NO	___________________________
Speech/Language Pathologist	☐YES	☐NO	___________________________
Neuropsychologist	☐YES	☐NO	___________________________
Audiologist (Hearing Test)	☐YES	☐NO	___________________________
Physical or Occupational Therapist	☐YES	☐NO	___________________________
Other________________________	☐YES	☐NO	___________________________

Does your child receive any current physical, occupational or speech therapy? ☐NO ☐YES (Explain): ___________
____

Educational History: School name/Address/Phone: ____
Grade:________________________ Teacher's Name:____
Does your child have any difficulty communicating at school?____
Please describe any special tutoring/therapy:____
Does your child have difficulty with attention, learning, reading, spelling, writing, math? (circle and explain)
____

Family and Social History:
List any brother/sisters and ages?____
Who lives in the home?____
Marital status of parents? ☐Married ☐Separated ☐Divorced ☐Other
Patient Tobacco Use? ☐YES ☐NO Alcohol Intake? ☐YES ☐NO Substance Dependency? ☐YES ☐NO
If any yes responses, please explain: ____

Activities:
In school: ____
Outside of school: ____

General Behaviors:
Do you think your child gets along well with other children? ☐YES ☐No Adults? ☐YES ☐NO
Does your child exhibit any clumsiness, hitting, tantrums or other behavior that interferes with social interaction?
☐NO ☐YES, explain:____
Please write down any other information that you feel would be important for us to know:
____
____

Speech Pathologist's notes: ____
____
____

Speech Pathologist: ______________________________ ____________ ______________________
Signature ID # Date/Time