Stony Brook Medicine

Name:_____
Date of birth: _____

Infant/Early Childhood (0-5 years)
Speech - Language Pathology History Form

Person completing form: □Patient □Spouse □Parent/Guardian □Other-Name_____
Mother's Name: _____ Father's Name: _____
Address: _____
Telephone: (home) _____ (work) _____ (cell) _____
Email:_____
Pediatrician (Name/Phone number):_____
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: _____

Pregnancy History: □Full Term □Premature _____ weeks
Please describe any illness/hospitalization of mother during pregnancy: _____
_____
Drug/alcohol/medication use before or during pregnancy: □ YES □ NO If yes, please explain: _____
_____

Birth History: □Stony Brook University Hospital □Other: _____
Delivery: □ Vaginal delivery □Caesarean delivery; Why? _____
Was the child one of a multiple birth? □Yes _____ □No Birth Weight: _____
Was anesthesia/medication given? □ YES □ NO If yes, what kind? _____

Complications / Treatments:	□ YES □NO	How Long
Cord around neck?	□ YES □NO	_____
Breathing Problems?	□YES □NO	_____
Transfusions?	□YES □NO	_____
Phototherapy?	□YES □NO	_____

Other: _____
Did the baby go home with the mother? □YES □NO How long after? _____

Speech Pathologist's notes: _____
_____
_____

Infant/Early Childhood (0-5 years) SLP History Form page 2/3 Name: _____

Motoric Development: □ Normal Development for head control (3-4 months), sitting (6-7 months), walking (12-15 months), toilet training (2½-3½ years), & eating □ Delayed or Later Development (Complete All Below)

			Age achieved/further information
Head support:	□YES	□NO	_____
Unsupported sitting:	□ YES	□NO	_____
Walking without holding on:	□YES	□NO	_____
Trained for bowel/bladder:	□YES	□NO	_____
Does he/she have any accidents?	□YES	□NO	_____
Does child have difficulty sucking?	□YES	□NO	_____
Does child have difficulty chewing?	□YES	□NO	_____
Does child drool?	□YES	□NO	_____

Current diet: □Regular □Cut up foods □Baby Food stage_____ □other_____

Speech – Language Development: □Normal Development for babbling (3-6 months), first words (12-16 months), & combining words phrases/sentences (2-3 years) □Delayed/Later Development (Complete All Below)

			Age achieved / further information
Babble:	□YES	□NO	_____
Meaningful Words:	□YES	□NO	_____
Combine two to three words:	□YES	□NO	_____

Current communication: □Verbal/sentence level □ Verbal/few words □Vocalizing □Gesturing □ASL
Does your child understand directions: □ YES □ NO Comments: _____

Has your child received:			Name/Location/Phone number of therapist	Frequency of treatment
Physical Therapy:	□YES	□NO	_____	_____
Occupational Therapy	□YES	□ NO	_____	_____
Speech Therapy	□YES	□NO	_____	_____
Psychology/Psychiatric Services	□ YES	□ NO	_____	_____

Medical History: Does the child have any of the following (past or present):

ADD/ADHD	□ YES	□ NO	Learning Disability	□YES	□NO
Allergies	□YES	□ NO	Heart Problems	□YES	□NO
Circle/describe: seasonal food medication			High Fevers	□YES	□NO
Asthma	□YES	□NO	Diabetes	□YES	□NO
Cancer	□YES	□NO	Epilepsy	□YES	□NO
Chicken Pox	□YES	□NO	Hepatitis	□YES	□NO
Colds	□YES	□NO	HIV Positive/ AIDS	□YES	□NO
Ear Infections	□YES	□NO	Respiratory Disease	□YES	□NO
Gastric Reflux	□YES	□NO	Seizures	□YES	□NO
Hearing Loss	□YES	□NO	Mental Retardation	□YES	□NO
Cerebral Palsy	□YES	□NO	Pneumonia/Bronchitis	□YES	□NO
Developmental Delays	□YES	□NO	Tracheostomy Tube	□YES	□NO

Please list any other medical history including surgeries/medications (and reason for medication):

_____
_____
_____

Speech Pathologist's notes: _____
_____
_____

Infant/Early Childhood (0-5 years) SLP History Form page 3/3 Name: _____

Educational History: □No School □Preschool □Elementary School □Homeschooled □Early Intervention
School name/telephone number:_____
How many days per week? □1 □2 □3 □4 □5 □Half day □Full day
Grade: _____ Teacher's Name: _____

Does your child have any concerns with attention, communication, or learning at school? _____
_____
Please describe any special tutoring/therapy: _____
_____

General Behaviors:
Does your child exhibit any of the following?

Clumsiness	□YES	□NO	Hitting	□YES	□NO
Tantrums	□YES	□NO	Biting	□YES	□NO
Head banging	□YES	□NO	Scratching	□YES	□NO

Do you think your child gets along well with other children? □YES □NO Adults? □YES □NO
Other: _____
If so, in response to what and how often? _____
_____

Family and Social History:

Has anyone in your family had?			Relationship to child
ADD/ADHD	□YES	□NO	_____
Trouble speaking clearly	□YES	□NO	_____
Hearing impairment	□YES	□NO	_____
Learning disability	□YES	□NO	_____
Mental retardation	□YES	□NO	_____
Genetic disorder	□YES	□NO	_____
Cleft lip/ cleft palate	□YES	□NO	_____
Speech delay	□YES	□NO	_____

Other: _____
List any brother/sisters and ages? _____
Who lives in the home? _____
Marital status of parents? □Married □Separated □Divorced □Other

Any other information that you feel would be important for us to know:
_____
_____

Speech Pathologist's notes: _____
_____
_____

Speech Pathologist: _____ _____ _____
Signature ID # Date/ Time