**GOEPFERT SPEECH ASSOCIATES, LLC**

**Diagnostic and Therapeutic Services for Children and Adults**

 **431 East Chocolate Avenue**

 **Hershey, PA 17033 Phone/Fax: (717) 533-1916**

**HISTORY QUESTIONNAIRE**

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_yrs.\_\_\_mos. Birthdate\_\_\_\_\_\_\_\_ Sex: M/F

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_

Name of person completing form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_

Describe your concerns and reason for evaluation referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTH AND PRENATAL HISTORY:

Describe any unusual illness, accident or conditions during pregnancy or delivery\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of pregnancy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications during pregnancy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of labor\_\_\_\_\_\_\_\_\_\_\_ Birth Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intensive care? Yes/No

Breathing problems? Yes/No Feeding problems? Yes/No

FAMILY HISTORY:

Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_

Education\_\_\_\_\_\_\_\_\_\_\_ Living with family? Yes/No Divorced or Separated? \_\_\_ Deceased?\_\_\_

Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_

Education\_\_\_\_\_\_\_\_\_\_\_ Living with family? Yes/No Divorced or Separated? \_\_\_ Deceased?\_\_\_

Other Siblings (names & ages)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEVELOPMENTAL HISTORY At what age did the infant first do the following: Crawl\_\_\_\_\_\_

Walk\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sit unsupported\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stand unaided\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink from a cup\_\_\_\_\_\_\_\_ Sleep through the night\_\_\_\_\_\_\_\_\_\_ Gain bladder control\_\_\_\_\_\_\_\_\_

Does the child prefer (circle) left or right hand? Seem uncoordinated or lose balance? Yes/No

Describe any chewing, swallowing, or drooling difficulties\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there other family members with speech, language, hearing or learning difficulties? Yes/No

If so, who(describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY Check if the child has had the following: \_\_\_\_Mumps \_\_\_\_Chicken Pox

\_\_\_Earaches \_\_\_Ear infections \_\_\_Frequent Colds \_\_\_Allergies \_\_\_Asthma

\_\_\_Bronchitis \_\_\_High Fever \_\_\_Tonsillitis \_\_\_Whooping cough \_\_\_Influenza \_\_\_Meningitis

\_\_\_Paralysis \_\_\_Convulsions \_\_\_Heart Disease \_\_\_Scarlet Fever \_\_\_Measles
Explain any other hospitalizations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL DEVELOPMENT Answer Yes or No. Is/Does child: Responsive to people\_\_\_\_\_

Responsive to objects?\_\_\_\_ Normally active?\_\_\_\_\_ Usually happy?\_\_\_\_ Take turns?\_\_\_\_

Demonstrate affection to others?\_\_\_\_ Enjoy others company?\_\_\_\_\_ Cooperate with others\_\_\_\_

Play with family members?\_\_\_\_ Play with children outside the family?\_\_\_\_ share?\_\_\_\_

Initiate a variety of play schemes?\_\_\_\_ Readily try new things?\_\_\_\_

Show concern when separated from parents?\_\_\_\_ Seem unaware of others?\_\_\_\_

Play mostly by himself?\_\_\_\_ Usually unhappy?\_\_\_\_ Cry frequently?\_\_\_\_ Bang Head?\_\_\_\_

Anger easily when frustrated?\_\_\_\_ Seem fearful of new things?\_\_\_\_ Rock while sitting?\_\_\_\_\_

Stare?\_\_\_\_ Seem hyperactive?\_\_\_\_ Seem underactive?\_\_\_\_ Resist discipline or direction?\_\_\_\_\_

Describe other behaviors observed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SPEECH AND LANGUAGE DEVELOPMENT At what age did the child do the following:

Respond to sounds in the environment\_\_\_\_\_ Coo and babble \_\_\_\_\_ Gesture and point\_\_\_\_\_

Say single words\_\_\_\_\_ Combine two words\_\_\_\_\_ Use sentences\_\_\_\_\_ What is the average sentence length?\_\_\_\_\_\_\_\_\_(words) Do you feel his/her vocabulary is age appropriate?\_\_\_\_\_\_\_\_

Does he/she readily attempt to communicate?\_\_\_\_\_ Verbalize excessively\_\_\_\_\_ Currently gesture or point to communicate?\_\_\_\_\_\_\_ Seem eager to communicate with others?\_\_\_\_\_\_\_\_\_\_

Are there any known defects of the tongue, palate, nose, throat, or ears?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel his/her articulation is age appropriate?\_\_\_\_\_\_ If not, what sound errors are noted?

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SCHOOL When did he/she start school?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of current school and grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any difficulties in school\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER INFORMATION Has the child had any of the following (please explain):

Speech evaluation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurological examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psycho-educational assessment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use this space to provide any additional information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What goals do you have and how do you feel that services at this office may be of help?\_\_\_\_\_\_\_

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