GOEPFERT SPEECH ASSOCIATES

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:
Father_____ Age_____
Address_____ Occupation_____
Education_____ Living with family? Yes/No Divorced or Separated? ___ Deceased?___
Mother_____ 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_____

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:_____
_____

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?
_____

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_____
_____
_____

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