

**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 \_\_\_\_\_

**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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_