



SAN ANTONIO HEAD & NECK SURGICAL ASSOCIATES, P.A. DBA

Ear, Nose & Throat Clinics of San Antonio, P.A.

Child's Name: _____ Male Female Date of Birth: _____

School/grade: _____ Person Completing Form: _____

Is child receiving speech therapy? _____ Where? _____ How often? _____

What is the primary language spoken in the home? _____



CHILD'S HEALTH HISTORY

Yes No

1. Was your child born prematurely? If yes, how many weeks? _____

2. Was your child admitted to the NICU following birth?
If yes, please explain:

3. Did your child have any birth injuries or congenital abnormalities?
If yes, please explain:

4. Were/are there any respiratory problems? If yes, explain:

5. Has your child ever had seizures? If so, on medication? _____

6. Has your child had frequent ear infections?

7. Has your child had tubes place in the ears?

8. Does your child have normal hearing and vision?
If not, explain:

9. Were there any delays in speech or language development?
If so, explain:

10. Were there any delays in fine/gross motor development such as writing , opening clasps,
walking, crawling, etc.
If so, explain:

11. Has your child had any major accidents or illnesses since birth requiring hospitalization or
surgery?
If so, explain:



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Yes No

12. Has your child been diagnosed with any recurring or on-going illnesses or conditions such as hearing or vision loss, ADD/ADHD, breathing difficulties, autism spectrum disorders, etc?
 If so, please explain what the diagnosis was and when it was given: _____

13. Has your child had PE tubes inserted? If **yes**, how many times have they been inserted? _____
 Insertion Date: _____

14. Do you have any concerns about your child's eating or swallowing habits?
 If so, explain: _____

15. Does/did your child suck his/her thumb? If so, when did they stop?

Please provide the following information on health care providers currently serving your child:

May we contact them? Yes No

Provider Name	Specialty	Phone

Please provide the following information on any medications your child is currently taking:

Name of Medication	Reason	Length of use	Side effects

Please provide the following information on any educational, developmental, medical, or psychological evaluations your child has had in the last three years. May we contact them? Yes No

Type of Evaluation	Evaluator (school, physician, etc)	Date of Evaluation	Do you have a copy?

SOCIAL HISTORY

Please indicate how your child gets along with the following people:

Parents:
Siblings: Names and ages of siblings:



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Please explain any significant behavior concerns such as recent changes or problem behaviors:

Please explain any significant changes in the child’s environment that we should be aware of:
(ex.: family illnesses, births, deaths, divorce, new school, move to new home, etc.)

EDUCATIONAL HISTORY

Child’s School/Day care: _____ May we contact them? Yes No
School/Daycare phone number: _____

Has anyone in your family been diagnosed with or had learning difficulties? Yes No
If so, please explain:

Please explain any concerns about your child’s learning as specifically as possible:

THERAPEUTIC GOALS

Please explain any concerns about your child’s speech as specifically as possible:

Speech Therapy:
