History Questionnaire
Gresham Speech Therapy
Jill Russell, MS, CCC/SLP

Confidential: the information you provide on this form will not be released to parties outside this agency without your consent. Please complete all information requested.

Date completed _____Completed by _____

Patient Name _____ Age _____ Birth Date _____

Address _____

Mother's Name (if patient is a child)

_____Phone_____

Address _____

Father's Name _____ Phone_____

Address _____

How was patient referred to this clinic?_____

What is your main concern at this time? _____

_____

_____

Primary Care Physician_____ Phone_____

Address_____

Orthodontist _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Does patient receive any type of therapy?_____If so, what type, where and when_____

_____

List other people living in the patient's home:

Name	Relationship to Child	Age

General Health

How is your (patient) general health?

_____

Any known syndrome or diagnosis?_____

Please name any medications patient takes on a regular basis_____

_____

Check if patient experiences any of the following:

Allergic reactions: _____

Meningitis:_____

High fever:_____ CMV:_____

Ear Infections:_____

Hospitalized?_____ If yes, for _____

_____

Myofunctional Concerns

What is patient's primary mouth rest posture? (i.e., open most of the time, open when sleeping, closed all the time) _____

Is it hard for patient to breathe freely through the nose?_____

Does patient have allergy or sinus problems? (If yes, please explain what child is allergic to)_____

_____

Does patient take any medications for allergies? _____

Does patient still have tonsils? _____

If no, when where they removed? _____

Does patient have history of tonsillitis? _____

Does patient drink more than one glass of liquid with meals? _____

Does patient have frequent digestive problems?_____

V. Associated Oral Behaviors

Check all that apply to patient:

Bite fingernails?_____

Chew or suck on things such as pencils, knuckles, or blankets?_____

Lick lips?_____ Prop the chin?_____

Thumb suck? (if yes, how long?)_____

Use a pacifier? (if yes, how long?) _____

Was child bottle-fed or breastfed? _____

How long? _____

Does your child use a sippy cup now, or in the past? If so, how long?_____

Is there anything else that is important to know?

_____

_____

_____

If patient is a child, may your he/she be photographed and/or videotaped for therapeutic/insurance reasons?

yes_____ no_____