Nevada Speech and Therapy Group

Quality In-Home Speech Therapy

PEDIATRIC MEDICAL HISTORY

Child's Name: ____________________________________

Parent's Name: ___________________________________

Referring Physician: _______________________________

Primary Care Physician: ____________________________

Emergency Contact Name and Number: _____________

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Current Medications and Dosages: _________________

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History of main complaint (describe present injury/illness, treatment received, and surgery if any):

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What functional difficulties has your child experienced because of this? _________________________________

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Medical History: ___________________________________

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Has your child had any major surgical procedures in the past 5 years? If yes, please list: ____________________

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Does your child have/had any of the following conditions, (Check any that are applicable):

☐Epilepsy/Seizures	☐Radiation Treatment
☐Hepatitis/Jaundice	☐Fainting
☐Cancer	☐Anemia
☐Heart Murmur	☐Leukemia
☐Hay Fever/Allergies	☐Tuberculosis
☐Diabetes	☐Asthma
☐Liver Disease	☐Other: ____________

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Does your child have any dietary restrictions? ________

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Has your insurance been billed for any therapy (physical, occupational, and/or speech) services during this calendar year?

Yes No

If yes, where were these services provided and approximately how many visits were billed? _________

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What grade is your child in and what school do they attend? ______________________________________

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Is therapy received in school? Yes No