

**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:

<u>Name</u>	<u>Relationship to Child</u>	<u>Age</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## 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 \_\_\_\_\_