



# Wee Speak Therapy & Learning Center

## Patient History

Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone (Father): \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone (Mother): \_\_\_\_\_

Emergency Contact (other than parents): \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Is it ok to leave a message at these numbers? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please specify:

Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_

Other Medical Conditions/Diagnoses: \_\_\_\_\_

Referred By: \_\_\_\_\_

Parent Concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current/Previous OT/PT/SLP Program: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

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Patient History Continued

Other Physicians: \_\_\_\_\_

(Orthoped, Neurologist, Ophthalmologist, etc)

Medications: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Orthotics/Equipment: \_\_\_\_\_

Significant Birth History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give consent for my child to undergo speech, occupational therapy, and/or physical therapy evaluations and participate in treatment outlined in the therapist's plan of care.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give consent for students and/or volunteers to observe and/or participate in the treatment of my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_