



Sensory Solutions, LLC

Physical, Speech, Occupational, and Nutritional Health Therapy for Children

Speech Therapy for Adults

Patient History form

***Please fill out the questionnaire as accurately and completely as possible.**

Name: _____ Birth Date: _____

Pronouns: _____

Referred by: _____

Reason for Referral: _____

Have you received prior therapy for this condition? Yes No

Patient Information:

Address: _____

Zip Code: _____ Cell Phone: _____ Home Phone: _____

Email: _____

Education: _____ Occupation: _____

Employer: _____ Work Phone: _____

Marital Status (Please check): Married Separated Divorced Widowed Single
 Domestic Partnership

Emergency contact information:

Name: _____ Relationship: _____

Phone Number: _____

Primary Care Physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

Is any language other than English used in the home: Yes No

If yes, what language(s): _____

SPECIALTY SERVICES YOU RECEIVE:

Audiologist

Behavior Therapist

Cardiologist

Chiropractor

Dietitian

ENT

Neurologist

Occupational Therapist

Corporate Office

10332 Old Olive St. Rd.
Creve Coeur, MO 63141
314.567.4707
fax 314.567.4505

St. Peters Location

4200 N Cloverleaf Drive, Suite J
St. Peters, MO 63376
636.922.4700
fax 636.922.4505

Florissant Location

235 Dunn Rd
Florissant, MO 63031
314.912.4704
fax 314.866.5849

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- Ophthalmologist Optometrist Orthodontist Orthopedist
- Physical Therapist Psychologist Psychiatrist Speech Pathologist
- GI
- Other (please specify): _____

MEDICAL HISTORY:

List illnesses/diseases/injuries/operations you have experienced:

- Illness: _____ Age: _____
- Illness: _____ Age: _____
- Illness: _____ Age: _____
- Injury/operation: _____ Age: _____
- Injury/operation: _____ Age: _____
- Injury/operation: _____ Age: _____

Has you experienced convulsions/seizures: Yes No
 Age: _____ Type: _____ Frequency: _____ Medication: _____

Allergies:

- None
- Seasonal
- Food
- Other

Please list all allergies: _____

Are you currently taking any medications/vitamins/supplements: Yes No
 If yes, type(s): _____

SYMPTOMS (CHECK ALL THAT APPLY):

- Frequent Headaches/Migraines

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- TMJD (Temporomandibular Joint Disorder)
- Jaw Clicking/Popping
- Teeth Grinding
- Tightness in Neck and/or Shoulders
- Articulation/Speech Sound Production Difficulties
- Sleep Apnea: Suspected Diagnosed If Diagnosed, When: _____
- Mouth Breathing
- Tongue Thrust
- Narrow Palate
- Inability to Clear Food from Teeth with Tongue
- Forward Head Posture
- Poor Overall Posture
- Acid Reflux or History of
- Congestion When Falling Asleep/Waking
- Occasional Bed Wetting
- Difficulty Falling Asleep or Staying Asleep
- Selective/Picky Eater
- Bad Breath
- Frequent Cavities
- Pain or Difficulty when Kissing
- Frequent Choking on Foods/Liquids
- Thumb Sucking
- Nail Biting
- Other (please specify): _____

HISTORY OF:

- Braces When and how many times: _____
- Invisalign When: _____
- Palate Expander When: _____
- Spacers When: _____
- Sleep Study When: _____

CURRENT RESPONSE DURING FEEDING:

Behavior	Always/Often/ Sometimes/Never	Additional Comments
Acid Reflux		
Choking		
Coughing		
Difficulty Chewing		
Drooling		

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Eating Too Fast		
Eating Too Slow		
Fails To Chew Food		
Gagging		
Hiccups		
Holding Food in Mouth		
Nasal Regurgitation		
Pockets Food		
Poor Intake		
Spillage of Food/Liquid		
Spits Out Food		
Stuffs Mouth		
Vomiting		

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