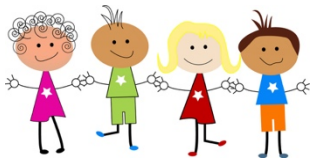
ABOUT MY CHILD • SPEECH THERAPY

Today's Date: ____/____/____

Child's Name: _____

Date of Birth: ____/____/____



Height: ___' ___" **Weight:** _____ **lbs**

How did you hear about us? _____

Emergency contact: _____ Phone: (____) ____-____
Relationship: _____

Child's school: _____ Grade: _____

What is the main reason you are seeking help for your child? _____

_____

MEDICAL STATUS

Food or medical allergies: _____

_____

Illnesses currently being treated: _____

_____

Medications presently taken: _____

_____

BACKGROUND

What are your primary concerns regarding your child's communication abilities? _____

_____

Has your child ever had a speech evaluation/screening? Yes No
If yes, where and when? _____

Has your child received speech therapy in the past? Yes No
If yes, where and when? _____

Has your child received any other evaluation or therapy (counseling, physical therapy, occupational therapy)?

Yes No

If yes, describe: _____

Does your child currently have an Individual Education Plan (IEP)? Yes No

Is your child aware of, or frustrated by, their speech-language skills? Yes No
If yes, explain: _____

_____

What do you see as your child's most difficult challenge at home? _____

_____

List any non-English languages spoken at home: _____
Which language(s) does the child prefer to speak? _____

BIRTH

Was there anything unusual about the pregnancy or birth? Yes No
If yes, describe: _____

_____

Has your child ever experienced any of the following?

Adenoidectomy	Yes	No	
Sleeping difficulties	Yes	No	
Tonsillectomy	Yes	No	
Ear tubes	Yes	No	If yes, when: _____
Encephalitis	Yes	No	
Sinusitis	Yes	No	
Frequent colds	Yes	No	
Ear infections	Yes	No	If yes, how often? _____
Seizures	Yes	No	
Thumb/finger sucking	Yes	No	
Allergies	Yes	No	
Head injury	Yes	No	
Vision problems	Yes	No	

Other serious injuries/surgeries: _____

_____

DEVELOPMENTAL

Write the approximate age at which your child achieved the following developmental milestones:

Babbled _____
Said first word _____
Put two words together _____
Spoke in short sentences _____
Sat alone _____
Walked _____
Toilet trained _____

Does your child…

Choke on food or liquids?	Yes	No
Put toys/objects in their mouth?	Yes	No
Brush their teeth and/or allow brushing?	Yes	No

SPEECH, LANGUAGE & HEARING

Does your child…

Repeat sounds, words or phrases over and over?	Yes	No
Understand what you are saying?	Yes	No
Retrieve common objects upon request? (ball, cup)	Yes	No
Follow simple directions? ("Please shut the door")	Yes	No
Respond correctly to who/what/where/when/why questions?	Yes	No

If no to any, describe: _____

_____

Circle one that best describes the manner in which your child currently communicates:

Body language
Sounds (vowels & grunting)
Single word
2-4 word phrases
5+ word sentences

BEHAVIORAL

Circle all characteristics that match your child's current behavior:

Cooperative
Easily distracted
Destructive/aggressive
Prefers playing alone
Poor eye contact
Withdrawn
Inappropriate behavior
Attentive
Separation anxiety
Easily frustrated
Impulsive
Expand: _____

_____

SCHOOL

Is your child having difficulty with any particular subjects? Yes No
If yes, describe: _____

What are your child's strengths and/or best subjects? _____

_____

What do you see as your child's most difficult challenge at school? _____

_____