Speech Language Success

WHERE COMMUNICATION FLOURISHES

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Today date: ______________

CLIENT INFORMATION

(All information provided is strictly confidential and will not be provided to any other agency without your written consent.)

Child's Name: ______________________________ Date of Birth: ___/____/____
Address: __________________________________ Sex: ☐ Male ☐ Female
Street Apt/Unit #
____
City State Zip

Mother's Name: ___________________________ Mother's Cell: (____) ____-_______
Mother's Occupation: _______________________ Mother's Work: (____) ____-_______
Email: ____

Father's Name: ____________________________ Father's Cell: (____) ____-_______
Father's Occupation: _______________________ Father's Work: (____) ____-_______
Email: ____

Marital Status of Parents: ☐ Single ☐ Married ☐ Divorced

Pediatrician: _____________________ Pediatrician's Number: (____) _____-_______

Referred by: ____________________ Reason for Referral: ______________________

General Information

Please describe your concerns about your child's development:
____
____
____

When did you first become concerned about your child? ______________________________

Is English the only language spoken in the home? ☐ Yes ☐ No
If not, what language(s)? ______________________________________
What is your child's stronger language? ______________________________

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Is your child currently attending a program/school? ◻ Yes ◻ No

If yes, grade/level: ____________________ Days scheduled: __________________________________

Name of the school: ____

Describe general progress and behavior in school:

____

Is your child in a special class or receiving tutoring? ◻ Yes ◻ No

Have any other specialists (occupational therapist, physical therapist, audiologist, psychologist, neurologist, neuropsychologist, ENT, orthopedist, etc.) seen your child? ◻ Yes ◻ No
If yes, please indicate the type of specialist, date (first seen), and the diagnosis/conclusion of the specialist.

Type of Specialist	Date	Diagnosis/Conclusion
______________________________	______________	______________________________________
______________________________	______________	______________________________________
______________________________	______________	______________________________________

Birth History

Were there any significant difficulties during pregnancy, labor, or delivery? ◻ Yes ◻ No

If so, please explain: ____

Did the mother take any medication or drugs during this pregnancy? ◻ Yes ◻ No

If so, please explain: ____

Expected due date: _____________

Duration of labor: __________hours

Type of delivery: ◻ normal ◻ breech ◻ C-section

Duration of pregnancy: ______weeks

Birth Weight: ______lbs. ______oz.

Method of delivery: ◻ natural ◻ induced ◻ forceps

Were there any complications at birth? ◻ Yes ◻ No

If so, please explain: ____

Did your child suffer from any of these difficulties during the **first 30 days of life**?

Jaundice: ◻ Yes ◻ No

Paralysis: ◻ Yes ◻ No

Feeding difficulties: ◻ Yes ◻ No

Oxygen needed: ◻ Yes ◻ No

Infections: ◻ Yes ◻ No

Other (please explain): ____________________

Medical History

Has your child been given any diagnosis including any medical conditions? ◻ Yes ◻ No

If yes, dates: ____________________ Diagnosis: ____

Has your child ever been hospitalized? ◻ Yes ◻ No

If yes, date(s): ___________________ Duration: ____

Reason for hospitalization: ____

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Has your child experienced any illnesses, injuries, or surgeries? ◻ Yes ◻ No
If yes, date(s): ____________________ Duration: ____
Please describe: ____

Any known allergies/food allergies? ◻ Yes ◻ No
If yes, please describe: ____

Any diet restrictions? ◻ Yes ◻ No
If yes, please describe: ____

Is your child currently taking any medications regularly? ◻ Yes ◻ No
If yes, please list: ____

Any other medical concerns? ◻ Yes ◻ No
If yes, please describe: ____

Has your child's vision been tested? ◻ Yes ◻ No
If yes, date of test: _________________ Results: ____

Motor Development

Do you have any concerns about your child's motor skills? ◻ Yes ◻ No
If yes, please explain: ____

Please indicate the approximate age in months for the following milestones:

sat alone:	_________months ◻ Never	babble:	_________months ◻ Never
crawl:	_________months ◻ Never	imitate speech:	_________months ◻ Never
stood up:	_________months ◻ Never	first word:	_________months ◻ Never
walk alone:	_________months ◻ Never	2-word combinations:	_________months ◻ Never
lost language:	_________months ◻ Never		

Does your child drool excessively for his/her age? ◻ Yes ◻ No

Speech and Language Development

Previous speech-language **evaluation**: ◻ Yes ◻ No
If yes, date: ___________________________________
Provided by: ___________________________________
Results: ______________________________________

Previous speech- language **therapy**: ◻ Yes ◻ No
If yes, date: ___________________________________
Provided by: ___________________________________
Results: ______________________________________

Do any family members have hearing or speech/language difficulties? ◻ Yes ◻ No
If so, please specify relationship to child and what the difficulty was:

____

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Which is your child's most frequent means of communication?
□ looking at objects □ pointing to objects □ physical manipulation □ gestures
□ sounds □ words □ phrases □ complete sentences

Does your child have difficulty pronouncing any sounds? □ Yes □ No
If so, which ones? ____________________

What percentage do you feel your child is understood: by you? ________% by others? ________%

Is your child easily frustrated when s/he is not understood? □ Yes □ No

Is your child aware of his/her communication difficulties? □ Yes □ No

Hearing

Do you suspect any hearing difficulty? □ Yes □ No

Has your child's hearing been tested? □ Yes □ No
If yes, date of test: ________________ Results: ____________________

Has your child experienced any ear infections? □ Yes □ No
If so, how many ear infections were there? 1 2 3 3 4 5 6 7 8 9 10+
At what age did the ear infection occur and end? ____________________
How were the ear infections treated? □ antibiotics □ PE tubes □ other: ________________

We thank you for your time filling out this form.

Completed by: ______________________________ Date: ___________ Relationship to child: ________________
Signature