Today's Date _____

Patient Information

Name: _____

Date of Birth: _____ Male/Female Twin? ☐ Y ☐ N Adopted? ☐ Y ☐ N

Street Address: _____

City/State: _____ Zip: _____ Home Phone: _____

Family Information

Father: _____
Name Age Employer Occupation

Address (if different from patient): _____

City/State/Zip: _____

Telephone: Home _____ Work or Cell _____ **Email:** _____

Mother: _____
Name Age Employer Occupation

Address (if different from patient): _____

City/State/Zip: _____

Telephone: Home _____ Work or Cell _____ **Email:** _____

Family members living with patient:

Name	Age	Relationship

Please list family members with speech, language or hearing problems: _____

What is the patient's first language? ☐ English ☐ Spanish ☐ Other(s) _____

What language(s) are used in the home? ☐ English ☐ Spanish ☐ Other(s) _____

Birth History

Were there any complications or unusual conditions during pregnancy or delivery? (RH incompatibility, hemorrhage, physical illness, accident,) If yes, please describe:

Length of gestation: _____

Birth weight: _____

Type of Delivery: _____

Complications after birth: _____

Was your child's hearing screened at birth in the hospital? ☐ Y ☐ N

If yes, what hospital? _____ Results? _____

Did your child have any swallowing or sucking difficulties? ☐ Y ☐ N

Were any other problems or abnormal physical findings identified at the hospital nursery? ☐ Y ☐ N

If yes, please describe: _____

_____

Development History

Motor Milestones	Age mastered
Hold head without support	
Sit without support	
Crawl	
Stand alone	
Walk alone	
Toilet trained	
Weaned from bottle/breast	
Feed self with spoon	
Drink from cup	

Use a spoon to eat	
Bladder control	
Bowel control	
Sleep through night	
Dress without help	

Speech and Language Milestones	**Age mastered**
Coo and babble	
Single words	
Use of two word phrases/sentences	
Use of complete sentences	

Is the child left or right handed? _____ Able to use: open cup ☐ spoon ☐ straw ☐

Any difficulty
____ Swallowing ____ Chewing ____ Drinking
____ Blowing ____ Drooling ____ Food allergies

Favorite Foods: _____

Aversive Foods (if any): _____

Medical Information

Primary Care Physician/Pediatrician:_____ Phone: _____

Other Physicians/Services (OT, PT…)

Specialty	Phone	Address
Specialty	Phone	Address

Current diagnosed conditions:

_____
(e.g., cerebral palsy, developmental delay, autism, list syndromes(s) other - see list below)

Diagnosed by: _____

Current Medications

Is your child currently receiving any medications? ☐ Y ☐ N If yes, please list drug name, dosage and the reason for the medication.

Please check if your child has had any of the following (and if so, at what age):

____ Chronic colds
____ Mumps
____ Diphtheria
____ Tonsillitis
____ Rheumatic fever
____ Enlarged glands
____ High fevers
____ Chicken pox
____ Croup
____ Meningitis
____ Sinusitis
____ Measles
____ Whooping cough
____ Pneumonia
____ Encephalitis
____ Chronic colds

Please check all that apply to the patient:

____ ADD
____ Allergies
____ Arthritis
____ Asthma
____ Cancer
____ Cerebral Palsy
____ CMV
____ Diabetes
____ Dizziness or balance
____ Ear Infections
____ Encephalitis
____ Frequent colds
____ Genetic Syndrome (specify below)
____ Head Injury
____ Hearing problems
____ Heart disease
____ HIV positive
____ Kidney/bladder disease
____ Meningitis
____ Seizures
____ Sensitivity to loud sounds
____ Swallowing problems
____ Stroke
____ Thyroid problem
____ Tuberculosis
____ Tubes in ears
____ Vision Problems

Please list any other medical problems not indicated above:

List any hospitalizations or surgeries:

Hospital	Procedure	Length of Stay	Date

Did your child's hearing, speech-language or behavior change after an illness or injury? ☐Y ☐N If yes, please explain:

Does your child wear corrective lenses or glasses? ☐Y ☐N

Any other vision problems? _____

Allergy History

Allergies to medications? ☐Y ☐N If yes, please list: _____

Allergies to foods? ☐Y ☐N If yes, please list: _____
Allergies to environmental agents? ☐Y ☐N If yes, please list: _____

___Pollen ____ Dust ____ Food ____ Animal ____ Other: _____

Speech-Language Information

Describe your child's speech/language problem:

_____

_____

When was the problem first noticed? _____

What is the child's reaction to the problem? _____

How does your child usually communicate?

____ gestures	____ single words	____ American Sign Language
____ sounds	____ short phrases	____ Signed English
____ pointing	____ complete sentences	

Does your child use speech?
____ Frequently ____ Occasionally ____ Seldom ____ Never

How many words are in your child's vocabulary? (check one)
____ under 25 ____ 25 – 75 ____ 75 - 100 ____ Over 100

Does your child continue to learn new words? ☐Y ☐N

Has your child ever talked better than now? ☐Y ☐N

Is the child's speech understood by?

Parents?	☐Y ☐N	Playmates?	☐Y ☐N
Strangers?	☐Y ☐N	Siblings?	☐Y ☐N
Unfamiliar Adult?	☐Y ☐N	Extended Family?	☐Y ☐N

Did speech development ever seem to stop for a time? ☐Y ☐N

Describe what it is like to have conversation with your child: _____

_____

Hearing Information

Does your child **often** watch your face closely when you are speaking to him or her?	☐Y	☐N	☐ Unsure
Does your child respond **only** to loud noise?	☐Y	☐N	☐ Unsure
Does your child respond to your voice?	☐Y	☐N	☐ Unsure
Does your child come when you call him/her?	☐Y	☐N	☐ Unsure

Do you think your child has a hearing loss? ☐Y ☐N ☐ Unsure

Does your child use hearing aids? ☐Y ☐N Date Received? _____

Cochlear implant? ☐Y ☐N Date Received? _____

Behavioral

Describe your child's ability to:

Get along with other children _____

Concentrate/pay attention _____

Learn_____

Cooperate/follow directions _____

Describe any unusual habits or fears _____

Sleep well? ☐Y ☐N

Cry appropriately? ☐Y ☐N

Laugh? ☐Y ☐N

Smile? ☐Y ☐N

Make wants/needs known? ☐Y ☐N How? _____

Educational Information

Has your child received Early Childhood Intervention (ECI) Services? ☐Y ☐N

If yes, please provide the following information:

Case Worker	Name of program	Address	Phone	Date

Is your child now enrolled in

____ Daycare? ____ Preschool? ____ Homeschool? ____ Public school? ____ Private school?

Name of school	Address	Phone	School District	Grade/Class

Name of teacher Phone Speech Therapist Phone

_____

What are your child's average grades?

Reading _____ Spelling _____ Not Applicable ____

Math _____Conduct _____

Does your child receive any special services at school? ☐Y ☐N

If yes, when was your most recent ARD meeting? _____

Type of Special Education services:

____ Content Mastery ____ Self-contained class ____ Speech-language therapy

____ Resource ____ Physical Therapy ____ Other, _____

____ Counseling ____ Occupational Therapy _____

Does your child appear to enjoy school? ☐Y ☐N

Does your child appear to enjoy his/her teacher? ☐Y ☐N _____

What are his/her favorite subjects/activities?_____

How many friends does your child have at school? ____ None ____ Some (1-3) ____ (Many 3+)

Therapy/Services History

Has your child ever received hearing testing or treatment and/or speech-language testing or treatment through the school system? ☐Y ☐N If yes, please list below:

Test/Treatment	Administered by	Address	Date

Has your child received any other special therapy or services not listed above **outside** the school system?

Type of Service	Service Provider(s)	Address	Date

Additional Background Information

Please list your child's extracurricular/social preferred play/activities (e.g. sports teams, church involvement, clubs, etc).

Please summarize what you consider your child's unique capacities/talents/strengths.

In your opinion, what is your child's main problem?

What do you want to learn from this evaluation?

Additional Comments?

Who referred you? _____

Thank you for taking the time to complete this form. This information will help us to provide the best service for your family.

_____ Relationship to patient_____

Signature of Person completing this form