

Welcome!

Thank you for choosing Therapy & Learning Center of GA, LLC. To help meet your child's needs. We sincerely appreciate this opportunity, and look forward to working with you and your child.

The attached New Client Paperwork packet includes important information about the practice. Please take time to fill out as much information as possible regarding your child's developmental history, as this information can be vital to the direction of the therapy plan. We understand that these forms can be time consuming however, it is important that we have as much information as possible prior to your visit so that we may provide the best possible service for your child. If your child has any recent evaluations completed by other health professionals (psychologist, IEP, etc.), please bring copies of these with you or you may email them to us in advance.

Our office policy is that you will need to place a credit card on file. This is because there is no "sign out desk" in the office and Amy, our director, handles the billing. The form is attached.

Sincerely,

Amy Squires, M.S.CCC-SLP
Speech and Language Pathologist
Director of Therapy and Learning Center of GA
GA License #: SLP 008235
ASHA Certification #: 12132094



**Therapy &
Learning
Center of GA**

Occupational and Speech Therapy Intake Form

Identifying Information:

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Phone 1: _____ Phone 2: _____

Parent/Guardian Names: _____

Mother's Occupation: _____ Father's Occupation: _____

Child lives with both parents? ___ Yes ___ No

Primary Language Spoken in Home: _____

Others living the home (names, ages, and relationship to patient): _____

Referral Source:

Pediatrician: _____ Phone: _____

Reason for referral: _____

Previous evaluations (list): _____

Therapy to date (list): _____

Describe the present problem: _____

Who noted the present Problem? _____ When? _____

How does the family react to the problem? _____

Have there been any significant changes in the last six months? If so, what? _____



Prenatal History:

Please check any complications during pregnancy

- | | |
|---|--|
| <input type="checkbox"/> Morning sickness | <input type="checkbox"/> Bleeding from vagina |
| <input type="checkbox"/> Premature contractions | <input type="checkbox"/> Edema (swelling) of hands, face |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Incompatible Rh factor |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Emotional strain | <input type="checkbox"/> Viral Infection |
| <input type="checkbox"/> High fever | <input type="checkbox"/> Cardiac Infection |
| <input type="checkbox"/> Excess vomiting | <input type="checkbox"/> Convulsions |
| | <input type="checkbox"/> Surgery |
| | <input type="checkbox"/> Amniotic fluid loss |

Other: _____

Were any of the following taken during pregnancy?

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Blood pressure pills | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Pills for nausea | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Diuretic |
| <input type="checkbox"/> Medication to prevent weight gain | <input type="checkbox"/> Medication to prevent miscarriage | |
| <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> Pain medication | |
| <input type="checkbox"/> Valium | <input type="checkbox"/> Prednisone | <input type="checkbox"/> Amphetamine |
| <input type="checkbox"/> Methadone | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Cocaine |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Other drugs: _____ | |
| <input type="checkbox"/> Cigarettes (10 or more per day) | | |
| <input type="checkbox"/> Two or more cups of coffee/tea per day | | |

How much weight did you gain? _____ Was client active in utero? _____

Pregnancy Length:

- | | |
|--|--------------------------------|
| <input type="checkbox"/> Full Term | |
| <input type="checkbox"/> Premature | If yes, how many weeks?: _____ |
| <input type="checkbox"/> Late Delivery (2+ weeks late) | If yes, how many weeks?: _____ |



Perinatal History

Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Labor was drug induced | <input type="checkbox"/> Caesarian section before onset of labor |
| <input type="checkbox"/> Epidural | <input type="checkbox"/> Caesarian section after onset of labor |
| <input type="checkbox"/> General anesthesia (mother unconscious) | |
| <input type="checkbox"/> Prolonged labor | |
| <input type="checkbox"/> Cord around neck | <input type="checkbox"/> Use of forceps |
| <input type="checkbox"/> Did not breathe at first | <input type="checkbox"/> Slow heartbeat |
| <input type="checkbox"/> Infant had seizures | <input type="checkbox"/> Infant was considered low birth weight |
| <input type="checkbox"/> Infant had jaundice | <input type="checkbox"/> Infant was jittery |
| <input type="checkbox"/> Infant had an unusual cry | <input type="checkbox"/> Infant required tube feeding |
| <input type="checkbox"/> Infant required oxygen | <input type="checkbox"/> Infant required blood transfusion |
| <input type="checkbox"/> Infant was in an incubator | <input type="checkbox"/> Infant cried excessively |
| <input type="checkbox"/> Infant was cyanotic (blue) | <input type="checkbox"/> Infant was limp/floppy |
| <input type="checkbox"/> Infant had congenital defects | |

If infant had congenital defects, what? _____

Other, explain: _____

Was this pregnancy unusual or abnormal in any way not already mentioned? _____

Length of labor: _____ Birth Weight: _____ Apgar rating: _____

Was mother dismissed before infant? _____ How long? _____

Why? _____

Any special instructions at dismissal? _____

Infant was: Bottle fed Breast fed

Complications _____

Please list all food and drug allergies:



Post Natal History

Please check all that did or do apply and give approximate dates:

Did Patient.....

- | | |
|--|--|
| <input type="checkbox"/> Reach out and prepare to be picked up | <input type="checkbox"/> Have frequent nightmares |
| <input type="checkbox"/> Want to be held a great deal | <input type="checkbox"/> Need parent's presence to fall asleep |
| <input type="checkbox"/> Want to be held sometimes | <input type="checkbox"/> Often sleep in parent's bed |
| <input type="checkbox"/> Resist being held | <input type="checkbox"/> Have difficulty sucking |
| <input type="checkbox"/> Awaken frequently | <input type="checkbox"/> Have a poor appetite |
| <input type="checkbox"/> Have difficulty falling asleep | <input type="checkbox"/> Have difficulty swallowing |
| <input type="checkbox"/> Have difficulty awakening | <input type="checkbox"/> Choke on food |
| <input type="checkbox"/> Sleep mostly between feedings but awaken when hungry | <input type="checkbox"/> Vomit after eating |
| <input type="checkbox"/> Sleep between some feedings, with long periods of wakefulness | <input type="checkbox"/> Spit up frequently |
| <input type="checkbox"/> Sleep little, but seems comfortable | <input type="checkbox"/> Appear to be insatiably hungry |
| <input type="checkbox"/> Show signs of physical activity while sleeping | <input type="checkbox"/> Crave sweets and other foods |
| <input type="checkbox"/> Rise and wander during night | <input type="checkbox"/> Refuse most foods |
| <input type="checkbox"/> Go on rampages at night, empty drawers, refrigerator | <input type="checkbox"/> Eat food quickly |
| | <input type="checkbox"/> Wander from table while eating |
| | <input type="checkbox"/> Act as if all foods taste same |
| | <input type="checkbox"/> Dislike foods of certain texture |
| | <input type="checkbox"/> Have other difficulties eating |

Comments: _____

Was Patient:

- | | |
|--|---|
| <input type="checkbox"/> Difficult to care for | <input type="checkbox"/> Often fussy/crying |
| <input type="checkbox"/> Extremely difficult to care for | <input type="checkbox"/> Almost always fussy/crying |
| <input type="checkbox"/> Inactive and quiet, but alert | <input type="checkbox"/> Diagnosed as having colic |
| <input type="checkbox"/> Inactive, sluggish and non-responsive | <input type="checkbox"/> Difficult to comfort |
| <input type="checkbox"/> Extremely active | <input type="checkbox"/> Extremely difficult to comfort |
| <input type="checkbox"/> Occasionally fussy/crying | <input type="checkbox"/> Medication prescribed |

Was client's behavior:

- Like younger children
- Like older children
- Different, but not like older or younger children

Comments: _____



Medical/Psychological History:

Please check diagnoses Patient has received:

- | | |
|--|--|
| <input type="checkbox"/> Aphasic | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Autistic | <input type="checkbox"/> Behavior Disordered |
| <input type="checkbox"/> Brain Damaged Disorder | <input type="checkbox"/> Central Auditory Processing |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Developmentally Delayed |
| <input type="checkbox"/> Emotionally Disturbed | <input type="checkbox"/> Hyperkinetic, Hyperactive |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Pervasive Developmental Delay |
| <input type="checkbox"/> Immature, Maturation Lag | <input type="checkbox"/> Dyslexia/Dyscalculia |
| <input type="checkbox"/> Minimal Brain Dysfunction (MBD) | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Muscle Disease | <input type="checkbox"/> Pain Disorder |
| <input type="checkbox"/> Speech/Language Disordered | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Tourette's Syndrome | <input type="checkbox"/> Static Encephalopathy |
| <input type="checkbox"/> Other Tic Disorders | <input type="checkbox"/> Hearing Impaired |

Other: _____

Please explain checked items in more detail: _____

Are immunizations current? Yes No

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

- | | |
|---|---|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Chicken Pox _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Chronic Cold _____ |
| <input type="checkbox"/> Chronic Ear Infections _____ | <input type="checkbox"/> Frequent Cough _____ |
| <input type="checkbox"/> Ear Tubes _____ | <input type="checkbox"/> Hearing Loss _____ |
| <input type="checkbox"/> Heart Trouble _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Meningitis _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Thyroid Issues _____ |
| <input type="checkbox"/> Sinusitis _____ | <input type="checkbox"/> Tonsillitis _____ |
| <input type="checkbox"/> Concussions _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Tremors _____ |
| <input type="checkbox"/> Other _____ | |

Has client experienced any of the following? Please check any/all that apply and indicate dates:

_____ Surgery
_____ Hospitalization other than for surgery
_____ Unconsciousness
_____ Emergency room treatment
_____ Other physical injuries

Additional Comments: _____



Motor Milestones

Sit alone Age _____
Crawl Age _____
Walk with Assistance Age _____
Walk without Assistance Age _____
Go downstairs Age _____
Ride a tricycle Age _____
Ride a 2-wheeled bike
(Without training wheels) Age _____

Daytime urinary training Age _____
Nighttime urinary training Age _____
Daytime bowel training Age _____
Nighttime bowel training Age _____
Independent toileting Age _____
Did client lose day/nighttime urinary
control after training was complete?
Age lost ___ Age regained ___
Did client lose day/nighttime bowel
Control after training was completed?
Age lost ___ Age regained ___

Comments: _____

Please check past/current sports participation:

- | | | |
|-------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Roller blading | <input type="checkbox"/> Lacrosse |
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Hockey | |
| <input type="checkbox"/> Football | <input type="checkbox"/> Soccer | |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Karate | |

Other: _____

Have other members of patient's biological family exhibited educational or physical difficulties of any kind. Please explain in detail.

Relationship to Client
(including maternal/paternal)

Nature of Problem

Please use the scale below and indicate the most appropriate answer when filling out the following sections:

1. Performs Well
2. Performs Fairly Well
3. Performs Poorly
4. Unable to Perform
5. Not Applicable

Other Motor Activities:

Coordinated Movements	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Swim	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



- 1. Performs Well**
- 2. Performs Fairly Well**
- 3. Performs Poorly**
- 4. Unable to Perform**
- 5. Not Applicable**

Activities of Daily Living

Maintain stable/suitable

posture at table	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Drink from a cup	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Drink from a glass	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Eat with a spoon	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Eat with a fork	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cut with a fork	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cut with a knife	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Butter bread	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Open milk carton	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Pour accurately from carton/thermos	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Open thermos	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Suck through a straw	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Turn on faucet	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Turn off faucet	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Wash hands	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Brush/comb hair	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Shampoo hair	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Brush teeth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Trim fingernails	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Trim toenails	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Take a bath	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Put on pullover garment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Remove pullover garment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Put on shirt	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Remove shirt	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Fasten/unfasten snaps	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Open/close zippers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Fasten/unfasten buttons	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Put on underpants	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Remove underpants	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Put on pants	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Remove pants	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Put on socks	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Remove socks	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



- 1. Performs Well**
- 2. Performs Fairly Well**
- 3. Performs Poorly**
- 4. Unable to Perform**
- 5. Not Applicable**

Put on shoes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Remove shoes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Tie shoes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Lace shoes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Put on hearing aids	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Remove hearing aids	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Put on braces	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Remove braces	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Household Chores

Make bed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Manage sweeping	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Use vacuum	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Wipe up spills	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Make a sandwich	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Use pushbuttons	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Open screw-top jars	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Load dishwasher	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Carry food to table	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Set table	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Clear table	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Use phone	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Construct with Legos	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



Communication

Please use the scale below and indicate the appropriate answer when filling out the following sections:

1. Never 2. Rarely 3. Occasionally 4. Frequently 5. Always

Patient....

Does not attempt to communicate	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Uses gestures to communicate	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Does not use language to communicate	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Responds negatively to unexpected loud noise	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has difficulty paying attention in proximity to other noise	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Seems confused as to direction of sounds	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Enjoys hearing strange noises	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Enjoys making loud noises	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Speaks loudly	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Enjoys music	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has a diagnosed hearing loss	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Speaks only to communicate needs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Stammers or stutters	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Speaks in incomplete sentences	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Hesitates or stops mid-sentence	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Seems to understand, but has trouble getting the words out	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has difficulty finding the right word	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Confuses words of opposite meaning (yesterday/tomorrow)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Confuses words that sound alike such as (hem/hen)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Refers to self by name, "Joe go to store"	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Speaks in own private language	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is unable to relate events	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is not an efficient communicator	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Speaks as if under great pressure	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Jumbles words in sentences	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has trouble pronouncing words	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Uses incorrect grammar	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has trouble following oral directions	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Does not seem to understand what was asked	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Talks constantly	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Lacks good, clear speech	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

List any other communication problems exhibited by client: _____



Speech and Hearing

Has your child ever received a speech evaluation/screening ? Yes No

If yes, where and when? _____

What were you told? _____

Has your child ever had a hearing evaluation/screening? Yes No

If yes, where and when? _____

What were you told? _____

Has your child received speech therapy previously? Yes No

If yes, where and when? _____

What was the focus of the therapy? _____

How well is your child understood by others? _____

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

Is your child aware of, or frustrated by, any speech/language difficulties? _____

If your child has had ear infections, how many? _____

How have the infections been treated? _____

Has your child had, or have, ear tubes? If yes, when did they receive the ear tubes and how long were they in place? _____



Language Development

Please give the approximate age your child achieved the following:

Babbled: _____

Spoke First Word: _____

Put Two Words Together: _____

Spoke in sentences: _____

Which sounds, if any, are incorrect? _____

How many words can your child say? _____

If fewer than ten, please list: _____

How long are your child's sentences? _____

Does your child have any difficulty understanding you? (If so, please describe) _____

Does your child have difficulty following directions? (If so, please describe) _____

Are there any speech or hearing problems in the immediate or extended family? (If so, please explain) _____

Does your child....

Choke on food or liquids?

Currently put toys/objects in his/her mouth?

Brush his/her teeth and/or allow brushing?

Please explain any of the above: _____

Does your child have difficulty (check for YES)....

Swallowing

Blowing

Chewing

Drooling

Drinking



What are your child's favorite foods? _____

List any food aversions: _____

Does your child (check for YES)....

Eat Well Cry appropriately Smile

Sleep Well Laugh

Does your child use sign language or other alternative/augmentative communication (e.g. Dynavox, Proloquo)?

Has your child attended daycare? _____

Number of regular playmates: _____

Favorite activities: _____

How does your child handle frustration? _____

What motivates your child the most? _____

What discipline works best? _____



Behavior

1. Never 2. Rarely 3. Occasionally 4. Frequently 5. Always

Patient.....

Dislikes being touched	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Prefers to touch rather than be touched	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Tends to feel more pain than others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Tends to feel less pain than others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has had vocal tics (clearing throat, grunting, barking yelping)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has had vocal tics (words, phrases, curses)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has had motor tics (twitches, jerks, blinks)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

If tics were present in the past, what types, at what age did they appear, how long did they last? Explain in detail.

Can they be suppressed? _____

Does the intensity and/or frequency vary over time? _____

Does stress make them worse? _____ Explain in detail. _____

1. Never 2. Rarely 3. Occasionally 4. Frequently 5. Always

Patient.....

Is generally disorganized	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has bedroom/toys disorganized	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is unable to put things in order	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Insists that bedroom/toys must be precisely ordered	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has no ability to keep a schedule	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Dresses in a disorderly fashion	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Approaches projects illogically	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Seems to do things the hard way	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is forgetful or loses belongings	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Confuses details	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Changes activities frequently	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is indecisive, changes mind often	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is impatient, cannot wait	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cannot tolerate frustration	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



	1. Never	2. Rarely	3. Occasionally	4. Frequently	5. Always
Patient....					
Does not finish what is started	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cannot sit through a board game	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Hums or taps fingers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Takes a long time to settle down	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Does things without thinking	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Talks too much	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Fidgets or squirms	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Bumps into things	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is accident prone	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Constantly wants things, is never satisfied	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Does things in a noisy way	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cannot play quietly for twenty minutes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Climbs onto cabinets/furniture without sense of fear	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is always on the go	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Runs, rather than walks	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Breaks things accidentally	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cannot keep hands to self	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Requires unusual confinement (harness, gates, etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is difficult to take to visit friends/relatives/shopping	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is difficult to leave with baby-sitter	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Needs constant supervision	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is hyperactive	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is hypoactive (under-active)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Dawdles	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Does things painfully slowly	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Daydreams	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Must be in control of situations	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Must do things own way	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Resists being taught how to do things	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Resists change in routine	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is overly cautious	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cries for the slightest reason	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Forgets social expectations	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Hears, but does not seem to listen	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cannot tolerate noisy, busy places	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Needs a calm, quiet atmosphere in order to concentrate	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



1. Never 2. Rarely 3. Occasionally 4. Frequently 5. Always

Patient....

Does sloppy work in spite of effort	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is willfully destructive	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Ignores social rules of modesty	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has no guilt for wrongdoing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has no remorse for hurting others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has excessive guilt at inappropriate times	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Believes rules apply only to others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Does not seem to learn from experience	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cannot tell right from wrong	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cheats, has to be winner	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Blames others for errors	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Always has an excuse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Complains of unfair treatment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Thinks everyone is against him/her	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Worries excessively	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is pessimistic (thinks things will go wrong)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has poor self-image, feels worthless	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Talks of harming self	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Attempts to harm self	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Complains of boredom	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is overly concerned about performance	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has rapid, unexpected mood changes	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is irritable	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has short fuse, explodes at any little thing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has hurt someone such that medical attention was necessary	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is insensitive to feelings of others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Gets into arguments	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Provokes adults	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Resists authority	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is defiant/belligerent when disciplined	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is stubborn	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Ignores directives without arguing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Purposely does the opposite of what is told	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Makes up untruths	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cannot be trusted alone	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Picks only on people smaller than self	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Extends self where there is no advantage	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Extends self only if advantage is clear	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Accepts favors, but makes no effort to return favors	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



1. Never 2. Rarely 3. Occasionally 4. Frequently 5. Always

Patient....

Hangs around with bad crowd	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Wants friends, but is rejected or avoided by others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Wants friends, but provokes them to anger	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Wants friends, but leads them into trouble	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has few friends, seems disliked	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Tends to choose friends with problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has no close friends	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has no close friends, but plays well in group	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cannot play well in a group because of:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<input type="checkbox"/> Poor coordination					
<input type="checkbox"/> Inability to take turns					
<input type="checkbox"/> Confusion regarding rules					
<input type="checkbox"/> Inattention, daydreaming					
<input type="checkbox"/> Other _____					

Has never had a friendship lasting more than six months.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Appears unconcerned about having friends	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Avoids being with peers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Prefers to play with older children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Prefers to play with younger children	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Prefers to play with adults	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is physically rough with others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is excessively bossy with peers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Gets into fights because of frustration	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Tattles	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is cold and untrusting of others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Resists sharing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Disrupts others' games/activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Gets feelings hurt easily by peers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Gets physically hurt by peers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Is overly submissive, easily led	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Has to be the leader	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Assumes role of clown	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Cannot keep up with peers	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Appears depressed, sad, gloomy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



Please check any that do/have applied:

- | | |
|---|--|
| <input type="checkbox"/> Has parrot-like speech, repeats mechanically | <input type="checkbox"/> Continues to have crying spells |
| <input type="checkbox"/> Has singsong quality to speech | <input type="checkbox"/> Rocks body for periods of time |
| <input type="checkbox"/> Speaks in a whisper | <input type="checkbox"/> Banged head beyond 2.5years |
| <input type="checkbox"/> Laughs or giggles for no apparent reason | <input type="checkbox"/> Has unusual fears |
| <input type="checkbox"/> Often covers ears | <input type="checkbox"/> Clings excessively to parent(s) |
| <input type="checkbox"/> Acts as if deaf | <input type="checkbox"/> Appears happier in the dark |
| <input type="checkbox"/> Had temper tantrums beyond age 4 years | <input type="checkbox"/> Resists having eyes covered |
| <input type="checkbox"/> Has breath-holding spells | <input type="checkbox"/> Bites, pinches, or hurts self |
| <input type="checkbox"/> Had prolonged crying spell before age 2.5 | <input type="checkbox"/> Picks skin, pulls hair, plucks eyebrows or lashes |
| <input type="checkbox"/> Bites, pinches or hurts others | <input type="checkbox"/> Bumps and/or pushes others |
| <input type="checkbox"/> Bites nails | <input type="checkbox"/> Grinds teeth |
| <input type="checkbox"/> Chews on nonfood items | <input type="checkbox"/> Holds hands in strange positions |
| <input type="checkbox"/> Holds body in strange positions for extended periods | |
| <input type="checkbox"/> Seems not to learn from experience, even if it hurts | |
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Ignores others |
| <input type="checkbox"/> Avoids making eye contact | <input type="checkbox"/> Shows indifference to affection |
| <input type="checkbox"/> Shows no attachment to parent(s) | <input type="checkbox"/> Shows attachment to unusual objects |
| <input type="checkbox"/> Stares at lights, water or shiny objects as if entranced | |
| <input type="checkbox"/> Whirls in circles | <input type="checkbox"/> Walks on toes |
| <input type="checkbox"/> Eats or attempts to eat strange substances such as leaves, garbage | <input type="checkbox"/> Smears stools |
| <input type="checkbox"/> Has strong aversion to being wet or dirty | <input type="checkbox"/> Has an unusual odor |
| <input type="checkbox"/> Drools | |
| <input type="checkbox"/> Has unusual ability, such as remembering jingles, recalling dates | |
| <input type="checkbox"/> Sees visions not seen by others | |
| <input type="checkbox"/> Hears voices not heard by others | |
| <input type="checkbox"/> Holds odd beliefs not based in reality | <input type="checkbox"/> Engages in rituals |
| <input type="checkbox"/> Repeats words, phrases, actions, over and over as if driven | |
| <input type="checkbox"/> Reacts violently to minor changes in environment | |
| <input type="checkbox"/> Steals when unsupervised | <input type="checkbox"/> Steals even while supervised |
| <input type="checkbox"/> Responds in bizarre ways to normal events | |
| <input type="checkbox"/> Has blank expression, stares for long periods | |
| <input type="checkbox"/> Breaks rules when unsupervised | <input type="checkbox"/> Breaks rules even while supervised |
| <input type="checkbox"/> Shows lack of awareness of location or time of day | |
| <input type="checkbox"/> Is reckless, fails to appreciate danger | |

Comments:



Patient has....

- Run away from home overnight
- Set a fire
- Lied to other than family member
- Been arrested, was in court or jail
- Been the cause of complaints about behavior from neighbors
- Been cruel to others younger than self
- Smoked tobacco
- Used marijuana, cocaine, heroin, or other drugs
- Sniffed glue
- Engaged in violence, aggression, assaults on others
- Engaged in extortion, threatening harm to others
- Engaged in breaking & entering
- Received moving traffic violations
- Killed or tortured animals
- Stolen from other family members
- Sent home due to behavior
- Used vulgar language
- Stayed out past curfew
- Gotten drunk or stoned
- Engaged in vandalism

School History

Please give details of school attendance as indicated.

	<u>DATES</u>	<u>AGE</u>	<u>NAME OF SCHOOL/ LOCATION</u>	<u>ANY PROBLEMS</u>
Pre-school Or Day-care	_____	_____	_____	_____
Kindergarten	_____	_____	_____	_____
Elementary	_____	_____	_____	_____
Middle	_____	_____	_____	_____
High	_____	_____	_____	_____



Academic Performance

**1. Performs well 2. Performs fairly well 3. Performs poorly
4. Unable to perform 5. Not applicable**

Use scissors		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Fine hand work (puzzles, models, etc.)		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Recognize letters	Age _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Recognize numbers	Age _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Draw	Age _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Print letters	Age _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Count money	Age _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Tell time on regular clock	Age _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Please check if any of the following were indicated as N (needs improvement), U (unsatisfactory), Or a grade of C or below on your child’s last report card or teacher conference.

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Spelling | <input type="checkbox"/> Handwriting |
| <input type="checkbox"/> Written Expression | <input type="checkbox"/> Math | <input type="checkbox"/> Science |
| <input type="checkbox"/> Social Studies | <input type="checkbox"/> Physical Education | |
| <input type="checkbox"/> Other _____ | | |

Educational History

Current School: _____ Grade: _____

Teacher: _____

Other professionals working with your child: _____

How does your child’s teacher describe his/her performance? _____

Has the teacher expressed concerns? If so, what? _____

Is your child having difficulty with any subjects? _____

What are your child’s favorite subjects? _____



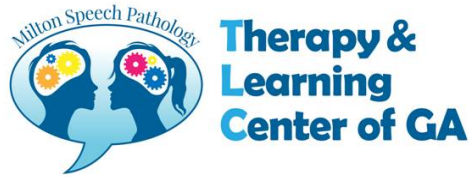
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If your child has been enrolled in Special Education services, has an Individualized Education Plan (IEP) been developed? (If so, please attach a copy)

Does your child have a 504 plan? _____ (If so, please attach a copy)

Please provide any additional information you believe might help us better understand your child in this process:

What do you hope to have happen as a result of this evaluation or screen?



Consent Form

This form must be completed before services can be initiated. If the client is under the age of 18 years, all legal guardians must sign the form.

Consent for Treatment: I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at Therapy & Learning Center of GA. I understand that I may terminate these services at any time.

Consent to Communicate with Insurance Company: I give consent to Therapy & Learning Center of GA and its employees/agents to communicate with my insurance company and to release any health information needed in order to authorize visits and collect payment.

Receipt of Policies and Procedures: I hereby attest that I have received a copy of Therapy & Learning Center of GA's Policies and Procedures, including payment policies, and have read, understood, and consented to be bound by its content.

Receipt of Patient's Rights: I hereby attest that I have received a copy of the Patient Rights notice, have read, and understood its content.

Receipt of Privacy Policy and Consent for Disclosure of Health Information: I have been provided a copy of Therapy & Learning Center of GA's Note of Privacy Policies detailing how my Medicaid record may be used and disclosed under Federal and State law. I understand that as part of the Therapy & Learning Center of GA's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and email only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Therapy & Learning Center of GA may refuse to treat me. I further understand that Therapy & Learning Center of GA reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

I acknowledge that if I elect service time beyond what my insurance company will cover that I am voluntarily paying for that service time.

Photocopy Authorization: I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (printed): _____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Legal Guardian Signature

Date



Therapy & Learning Center of GA

Credit Card Payment Authorization Form

Sign and complete this form to authorize Therapy & Learning Center of GA to make a debit to your credit card listed below. We require that patients keep a credit card on file for payment. This is because we do not have front office staff to process your card each day.

By signing this form you give us permission to debit your account for services rendered.

Please complete the information below:

I _____ authorize Therapy and Learning Center of GA to charge my credit card account for the amount indicated on my bill on or after the date of my child's service. If I am using insurance, the credit card will be processed after the insurance company provides and EOB outlining the negotiated rate for services. I will be notified of this rate before my credit card is processed. This payment is for Speech and Language Therapy, or Occupational Therapy, or Tutoring. Credit cards are processed at the end of the week.

Billing address: _____

Phone#: _____

City, State, Zip: _____

Email: _____

Account Type: <input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover
Cardholder Name: _____		
Card Number: _____		
Expiration Date: _____	CVC: _____	

SIGNATURE: _____ DATE: _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount explained to me. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form and for the amount explained to me.



Teacher Questionnaire for Occupational Therapy

Patient Name: _____ Date of birth: _____

Patient's Grade Level: _____

Your Name: _____ Today's date: _____

Relationship to patient: _____

Please consult with or have your child's teacher actually complete the following questions.

	1. Never	2. Rarely	3. Occasionally	4. Frequently	5. Always
Patient....					
Is slow to complete schoolwork	1	2	3	4	5
Is slow to complete projects of own selection	1	2	3	4	5
Avoids doing homework	1	2	3	4	5
Seems to take all night for homework	1	2	3	4	5
Loses homework	1	2	3	4	5
Turns in homework	1	2	3	4	5
Shows wide variety in quality of work day to day	1	2	3	4	5
Checks over work	1	2	3	4	5
Avoids written work	1	2	3	4	5
Completes reading tasks	1	2	3	4	5
Completes assignments without supervision	1	2	3	4	5
Is interested and motivated	1	2	3	4	5
Concentrates only on a one-to-one or small group basis	1	2	3	4	5
Works better in the morning	1	2	3	4	5
Works better in the afternoon	1	2	3	4	5
Is able to pace work/budget time	1	2	3	4	5
Is able to adjust to new situations/settings	1	2	3	4	5
Is able to adapt to changes in routine	1	2	3	4	5
Disturbs classmates	1	2	3	4	5
Takes turns	1	2	3	4	5
Maintains control on the playground, on the bus or in the lunchroom	1	2	3	4	5
Seems unruly and argumentative	1	2	3	4	5
Gets into fights	1	2	3	4	5
Is easily frustrated	1	2	3	4	5
Is unusually excitable	1	2	3	4	5
Has mood fluctuations, often unrelated to situation	1	2	3	4	5
Seems very active in class	1	2	3	4	5
Calls out in class	1	2	3	4	5



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	1. Never	2. Rarely	3. Occasionally	4. Frequently	5. Always
Patient...					
Makes noises in class	1	2	3	4	5
Talks excessively	1	2	3	4	5
Seems easily distracted	1	2	3	4	5
Asks to have things repeated	1	2	3	4	5
Listens in class	1	2	3	4	5
Has gotten lost within building	1	2	3	4	5
Seems slow to respond	1	2	3	4	5
Can sequence alphabet or numbers easily	1	2	3	4	5
Is able to comprehend a story	1	2	3	4	5
Confuses the order of numbers	1	2	3	4	5
Has difficulty copying from a book	1	2	3	4	5
Has difficulty copying from chalkboard	1	2	3	4	5
Jumbles letters in words	1	2	3	4	5
Reverses letters (d or b, etc.)	1	2	3	4	5
Rotates letters (p for b, etc.)	1	2	3	4	5
Reverses words (was for saw, etc.)	1	2	3	4	5
Loses place when reading, even if not interrupted	1	2	3	4	5
Approaches schoolwork in a disorganized manner	1	2	3	4	5
Has had school request help in managing behavior	1	2	3	4	5

Please indicate how many times client has been truant from school: _____

If client has ever been suspended from school, please give grade levels and describe offenses.

If client has ever been expelled from school, please give grade levels and describe offenses.

Does client read for pleasure? _____

Does client have any special interests or hobbies? Please specify: _____

What is client's favorite activity? _____

What is client's least favorite activity? _____

Does client use a computer at school? _____ What kind? _____

Does client have use of a computer at home? _____ What kind? _____



Therapy & Learning Center of GA

Policies and Procedures

Appointments:

Please arrive at your appointment 5 minutes early. In the event that you arrive late for your appointment, the appointment may be shortened due time constraints. If you must cancel an appointment, please call immediately. We understand that life happens. We have a 24 hour cancellation policy. **Therefore, please cancel appointments scheduled for the following day before 10 pm the evening prior via email, phone or text. The full service fee will be charged for no shows and last minute cancellations.** In the case of a child's illness, cancellations will be accepted before 8 am. **This includes school visits.** Please do not count on your child's school to notify MSP.

Patients are required to attend 75% of speech sessions. In the event that attendance drops to 50% over 2 months, we reserve the right to forfeit your child's space. **After 2 no show appointments (no call, no email, no text) for any reason, we reserve the right to forfeit your child's space.**

This does not apply to social skills groups. Social skills group students will be offered one make up session free of charge after the semester to cover the cost of all missed sessions. One hour social skills group lessons allow for 50 minutes in group and 10 minutes group/parent education.

Fees:

A schedule of fees can be obtained from our website. **You are required to inform us about changes in insurance. In the event that you fail to inform us and the insurance denies the claim, you will be responsible for the full payment.** Enrollment in social skills groups requires a *non-refundable payment* for the first 50% of classes upon enrollment. For example, when you enroll for an 8 class session, the fee for 4 sessions will be due 1 week prior to the start of group. The remainder is due after the 3rd class. We will charge your card after the 3rd class automatically. We will hold 1 make-up class free of charge after the end of the session for all students who have missed classes. **Verification of insurance is not a guarantee of payment. In the event that your insurance does not pay for service, you will be responsible for the fee. It is your responsibility to let us know if your insurance changes.** If you do not let us know and we do not have authorization for treatment from the new company, they may not pay and you will receive a bill.

Schools: There is a \$10 travel fee when therapists see patients at school.

Times: As per the consent form, if you elect to a service time that is beyond what is covered in your insurance, you are voluntarily agreeing to pay for the extra time as per your insurance's adjusted rate.

CAMP: Should you need to cancel camp 4 weeks prior, 100% of your payment will be refunded. Should you need to cancel camp 2-3 weeks prior 50% of your payment will be refunded. Should you need to cancel camp less than 1 week prior, 25% of your payment will be refunded.

Print Client's Name

Relationship to Client

Signature of Parent or Legal Guardian

Date