Please complete and submit this form prior to your child’s evaluation. This will provide the therapist adequate time to review information and select appropriate assessment material. This form may be filled out by hand or online.

General Information

Name: Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:

Nicknames:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:

Address: Phone:

City: Zip:

Person completing form:

**Who is at home?**

Adult #1 Name: Age:

Occupation: Phone:

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adult #2 Name: Age:

Occupation: Phone:

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you like to be contacted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other members of the house**:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship | Age | Note |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Referred by: Phone:

Pediatrician: Phone:

Address:

Family members with Speech, Language, Hearing, or Learning difficulties?

|  |  |
| --- | --- |
| Family Member | Difficulty |
|  |  |
|  |  |
|  |  |
|  |  |

What languages does the child speak? What languages does the child understand? What is the child’s dominant language?

|  |  |  |  |
| --- | --- | --- | --- |
| Language | Understand | Speak | Dominant |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

What languages are spoken in the home? What is the dominant language spoken?

With whom does the child spend most of his or her time?

Describe the child’s speech-language problem (Grammar, sounds, etc).

How does the child usually communicate (gestures, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does he or she feel about it?

Have any therapy specialists seen the child (Physical Therapist, Occupational Therapist, ABA, etc.)? Who and when?

|  |  |  |  |
| --- | --- | --- | --- |
| Therapy | Where | Times a week | Length of sessions |
| PT |  |  |  |
| OT |  |  |  |
| ABA |  |  |  |
| Other: |  |  |  |
| Other: |  |  |  |

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen the child? Please elaborate.

Please fill out the following chart about the child’s speech and language development milestones.

|  |  |  |  |
| --- | --- | --- | --- |
| Skill | Age | Skill | Age |
| Babbling |  | First sentence |  |
| First word |  | Conversation engagement |  |
| 2 words together |  |  |  |

Longest sentence/phrase/babble the child has said: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prenatal and Birth History

Birth Mother’s general health during pregnancy (illnesses, accidents, medications, etc.).

Prescriptions/non prescriptions taken during pregnancy:

Length of pregnancy : Birth weight: \_\_\_\_\_\_\_

Circle type of delivery: Vaginal/ Planned Cesarian / Emergency Caesarian / Breach /

Oher: \_\_\_\_\_\_\_\_\_\_\_

Any complications prior or during delivery?

Current Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Asthma Chicken pox Colds

Croup Dizziness Draining ear

Ear infections Encephalitis German measles

Headaches High fever Influenza

Mastoiditis Measles Meningitis

Mumps Pneumonia Seizures

Sinusitis Tinnitus Tonsillitis

Other

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications or allergies? If yes, please identify.

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl Sit Stand

Walk Feed self Dress self

Use toilet

Does your child do the following?

Name simple objects (e.g., dog, car, tree) \_\_\_\_\_\_\_\_\_Examples:

Use simple questions (e.g., Where’s doggie?) \_\_\_\_\_\_\_\_\_\_\_ Examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bottle-Fed or Breast-Fed Weaned off Bottle age:\_\_\_\_\_\_\_\_\_\_\_

Where there difficulties feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child have difficulty walking, running, or participating in other activities that require small or large muscle coordination?

Does your child have any formal diagnosis? When and where were they diagnosed?

|  |  |  |
| --- | --- | --- |
| Diagnosis | Where diagnosed? | When diagnosed |
|  |  |  |
|  |  |  |
|  |  |  |

Hearing Evaluation Date:\_\_\_\_\_\_\_\_\_\_\_ PASS/FAIL

History of Ear Infections YES/NO PE Tubes YES/NO

Vision Evaluation Date: \_\_\_\_\_\_\_\_\_PASS/FAIL

Educational History

Daycare / Preschool / T-K / School / Home School

School: Grade:

Teacher(s):

How is the child doing academically (or pre-academically)?

Does the child receive special services? If yes, describe.

How does the child interact with others (Extended Family, Siblings, Adults, Non-Family Children) (e.g., shy, aggressive, uncooperative)?

If enrolled for special education services, has an IEP or IFSP been developed?   
(If yes, please have a copy of the IEP/IFSP available)

Child’s favorite Activity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s least favorite Activity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Extra-Curricular Activities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide any additional information that might be helpful in the evaluation or remediation of the child’s problem.

Person completing form:

Relationship to client:

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: