Physical, Occupational Speech & ABA Therapy

IDENTIFYING & FAMILY INFORMATION

Patient's Name: ______________________________ Patient's DOB: ____________________

Patient's Sex:☐Male ☐Female Patient's Cell Phone (if applicable): _________________

Patient's Address: ____

____

Referring Doctor's Name and Address: ____

Referring Doctor's Phone and Fax Numbers: ______________________________________

Caregiver 1 Name: ____________________________ Caregiver 1 Email: ________________

Caregiver 1 Cell Phone: __________________ Caregiver 1 Other Phone: _______________

Caregiver 1 Address: ____

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Caregiver 2 Name: ____________________________ Caregiver 2 Email: ________________

Caregiver 2 Cell Phone: __________________ Caregiver 2 Other Phone: _______________

Caregiver 2 Address: ____

____

Caregiver 3 Name: ____________________________ Caregiver 3 Email: ________________

Caregiver 3 Cell Phone: __________________ Caregiver 3 Other Phone: _______________

Caregiver 3 Address: ____

____

Patient lives with (check one):

☐ Both Birth Parents ☐ Adoptive Parents

☐ One Parent ☐ Parent and Stepparent

☐ Foster Parents ☐ Other ________________________

Other Individuals in the Patient's Home:

Name	Age	Sex	Relationship to Patient

Do any family members have speech/language/hearing concerns? ☐**Yes** ☐**No**

If yes please describe. ____

____

Is there a language other than English spoken in the home? ☐**Yes** ☐**No**

If yes, which one(s)?____

Does the patient speak the language(s)? ____

Does the patient understand the language(s)? ____

Which language does the patient prefer to speak at home? ______________________________

BIRTH HISTORY

How many months was the patient's biological mother pregnant before giving birth?

____

Was there anything unusual about the pregnancy or birth? ☐**Yes** ☐**No**

If yes, please describe. ____

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Did the patient go home with his/her mother from the hospital? ☐**Yes** ☐**No**

If the patient stayed at the hospital, please describe why and how long. ____________________

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MEDICAL HISTORY

List any medications the patient takes: ____

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____

List any allergies: ____

____

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Has the patient had any of the following?

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Breathing difficulties
- ☐ Chicken Pox
- ☐ Chronic Colds
- ☐ Ear Infections
- ☐ Ear Tubes
- ☐ Encephalitis
- ☐ Flu
- ☐ Head Injury
- ☐ High fevers
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Seizures
- ☐ Sinusitis
- ☐ Sleeping difficulties
- ☐ Thumb/finger sucking
- ☐ Tonsillectomy
- ☐ Tonsilitis
- ☐ Vision difficulties

Other serious injury(ies): ____

____

Has the patient been diagnosed with any of the following?

- ☐ Autism Spectrum Disorder
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Cleft Palate/Lip
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Fibromyalgia
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Immunosuppre-ssion
- ☐ Long-Term Intubation
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Traumatic Brain Injury
- ☐ Tracheotomy

Other medical diagnosis(es): ____

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SCHOOL HISTORY

Name of school and grade or name of daycare and length of time enrolled at daycare:

____

What are the patient's strengths and/or best subjects? ___________________________

____

____

Is the patient having difficulty with any subjects? If so, which? ____________________

____

____

Does the patient have an IEP? ☐ **Yes** ☐ **No**

If yes, please bring a copy of the IEP to the patient's evaluation. If this is not possible, please describe the services provided on the IEP. ____

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SPEECH-LANGUAGE INFORMATION

What is the main concern regarding the patient's speech and language?

____

____

____

Tell the approximate age the patient achieved the following milestones:

- babbled ___________
- said first word(s) ___________
- put two words together __________
- spoke in short sentences ___________

Behavioral Characteristics of the Patient:

☐ Aggressive Behavior
☐ Attentive
☐ Cooperative
☐ Destructive Behavior
☐ Easily Distracted/ Short Attention
☐ Easily Frustrated/ Impulsive
☐ Inappropriate Behavior
☐ Poor Eye Contact
☐ Restless
☐ Self-Abusive Behavior
☐ Separation Difficulties
☐ Stubborn
☐ Willing to try new activities
☐ Withdrawn

☐ Other behaviors (please describe) ____
____

Does the patient:

☐ Repeat sounds, words or phrases over and over?

☐ Understand what you are saying?

☐ Retrieve/point to common objects upon request (ball, cup, shoe)?

☐ Follow simple directions ("Shut the door" or "Get your shoes")?

☐ Respond correctly to yes/no questions?

☐ Respond correctly to who/what/where/when/why questions?

The patient currently communicates using:

☐ Body language/the patient is nonverbal

☐ AAC Device
  - If so, which device ____

☐ Sounds (vowels, babbling)

☐ Words (shoe, doggy, up)

☐ 2-to-4-word phrases/sentences

☐ Sentences longer than four words

☐ Other (please describe) ____
____

What is the main goal for the patient's speech and language therapy?

____

____

____

Has the patient ever had a hearing evaluation/screening? ☐ **Yes** ☐ **No**

If yes, where and when? ______________________________

If yes, what were the results of the evaluation/screening? ______________________

Has the patient ever had a speech evaluation/screening? ☐ **Yes** ☐ **No**

If yes, where and when? ______________________________

If yes, what were the results of the evaluation/screening? ______________________

____

____

Has the patient ever had speech therapy? ☐ **Yes** ☐ **No**

If yes, where and when? ______________________________

If yes, what were they working on? ___________________________

____

Does the patient have feeding/swallowing difficulties? ☐ **Yes** ☐ **No**

If yes, please describe. ______________________________

____

____

Has the patient received any other evaluations or therapy (physical therapy, occupational therapy, counseling, etc.)? ☐ **Yes** ☐ **No**

If yes, please describe. ____

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Is the patient aware of, or frustrated by, their speech/language difficulties? ☐ **Yes** ☐ **No**

If yes, please describe. ____

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Are the patient's speech/language difficulties the same at home and school? ☐ **Yes** ☐ **No**

If no, please describe. ____

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