Let's Talk Therapy

PATIENT REGISTRATION FORM

Date Completed: _____

Identifying and Family Information

Child's Name: _____
Date of Birth: _____ Sex: □ M □ F
Age: ____
Mother's Name: _____ Father's Name: _____
Home Phone: _____ Home Phone: _____
Cell Phone: _____ Cell Phone: _____
Work Phone: _____ Work Phone: _____
Address: _____ Address: _____
_____ _____
E-mail:_____ Email: _____

Child's Physician

Doctor's Name: _____ Practice: _____
Doctor's Phone: _____ Doctor's Fax: _____

Child Lives with (check one):

One Parent□ Foster Parents □ Birth Parents □
Other□ Parent and Step-Parent □ Adoptive Parents □ _____

Other Children in the Family:

Name Age Sex Grade Presence of Speech/Hearing/Learning Problems

_____
_____
_____
_____

Is there a language other than English spoken in the home? Yes□ No □
If yes, what language? _____
Does the child speak the language? Yes□ No □
Does the child understand the language? Yes□ No □
Who else speaks the language? _____
Which language does the child prefer to speak at home? _____
What are the child's interests? What does he/she enjoy?

_____
_____

Birth and Medical History

Was there anything unusual about the pregnancy or birth? Yes □ No □
If yes, please describe. _____
_____
_____
How old was the mother when the child was born? _____
Was the mother ill during the pregnancy? Yes □ No□

If yes, please describe. _____
_____
How many weeks was the pregnancy? _____
Did the child go home with his/her mother from the hospital? Yes☐ No☐
If the child stayed at the hospital, please describe reason and length of stay.
_____
_____

Has your child had any of the following?

☐ Adenoidectomy	☐ Encephalitis	☐ Seizures
☐ Allergies	☐ Flu	☐ Sinusitis
☐ Breathing Difficulties	☐ Head Injury	☐ Sleeping Difficulties
☐ Chicken Pox	☐ High Fevers	☐ Thumb/Finger Sucking Habit
☐ Colds	☐ Meningitis	☐ Tonsillectomy
☐ Ear Infections How often? _____		
☐ Mumps	☐ Tonsillitis	☐ Ear Tubes
☐ Scarlet Fever	☐ Vision Problems	

Other serious injury/surgery:
_____
_____

Has your child been diagnosed with any of the following?

☐ Attention Deficit Disorder	☐ Central Auditory Processing Disorder
☐ Sensory Integration Disorder	☐ Attention Deficit Disorder with Hyperactivity
☐ Autism	☐ Specific Learning Disability - Reading, Written Expression, and/or Math
☐ Asperger's Syndrome	☐ Epilepsy
☐ Down Syndrome	☐ Stroke
☐ Mental Retardation	☐ Behavior or Emotional Disorder
☐ Pervasive Developmental Disorder	☐ Other _____

Is your child currently (or recently) under a physician's care? Yes ☐ No ☐
If yes, why? _____
_____
Please list any medications your child takes regularly:
_____
_____
Does your child have any allergies? Are there any precautions that should be taken with the child?
_____
Please describe any pertinent family medical history (i.e. mother, father, siblings, and grandparents):
_____
_____
_____

Please give the approximate age your child achieved the following developmental milestones:

_____ Babbled	_____ Toilet trained
_____ Used single words meaningfully	_____ Sat alone
_____ Began combining words	_____ Walked
_____ Spoke in short sentences	_____ Grasped crayon/pencil

Does your child...
(Check all that apply)
☐ choke on food or liquids? ☐ Is your child a picky eater?
☐ currently put toys/objects in his/her mouth?
☐ brush his/her teeth and/or allow brushing?

Does your child...
(Check all that apply)

- 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?

Your child currently communicates using...
(Check all that apply)

- body language (pointing, looking, gesturing)
- sounds (vowels, grunting)
- words (shoe, doggy, up)
- two- to four-word sentences
- sentences longer than four words
- other _____

Behavioral Characteristics:
Your child is/demonstrates:
(Check all that apply)

- cooperative
- attentive
- willing to try new activities
- easily distracted/short attention
- plays alone for reasonable length of time
- destructive/aggressive
- easily frustrated/impulsive
- restless
- poor eye contact
- stubborn
- withdrawn
- self-abusive behavior
- separation difficulties
- inappropriate behavior

Do you feel the child has a speech and/or language problem? Yes No
If yes, please describe. _____
_____
_____

Do you feel the child has a hearing problem? Yes No
If yes, please describe. _____
_____
_____

Has he/she ever had a speech evaluation/screening? Yes No
If yes, where and when?
_____
What were the results? _____
_____
_____

Has he/she ever had a hearing evaluation/screening? Yes No
If yes, where and when? _____
What were the results? _____
_____
_____

Has the child ever had speech therapy? Yes No
If yes, where and when? _____
What was he/she receiving therapy for?
_____
_____

Has the child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? Yes □ No□
If yes, please describe. _____
_____
_____
Is your child aware of, or frustrated by, any speech/language difficulties?
_____
What do you see as your child's most difficult problem in the home?
_____
_____
What do you see as your child's most difficult problem in school?
_____
_____

If the child is in school, please answer the following:
Name of school: _____
Grade: _____
Teacher's name: _____
Has the child repeated a grade?
_____
What are the child's strengths and/or best subjects?
_____
Is the child having difficulty with any subjects?
_____
_____
Is the child receiving help in any subjects?
_____
_____

Please add any other information that may be useful in treating your child.
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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