
Phone 269-254-8130 | Fax 866-376-0467
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## Patient Information

| | |
|---|---|
| Name: | |
| Birthdate (mm/dd/yyyy): | Sex: ( ) Male ( ) Female |
| Diagnosis: | |
| Physician Name: | |
| Physician Office: | |
| Reason for Referral: | |
| Would you like to receive text/email appointment reminders? ( ) Yes ( ) No<br>If yes, provide your preferred number/email: | |

## Parent/Caregiver Information

| | |
|---|---|
| Name: | |
| Relationship to Patient: ( ) Mom ( ) Dad ( ) Foster Parent<br>( ) Other _____ | Sex: ( ) Male<br>( ) Female |
| Address: | |
| Preferred Phone: | |
| Alternate Phone: | |
| Preferred Email: | |

## Parent/Caregiver Information

| | |
|---|---|
| Name: | |
| Relationship to Patient: ( ) Mom ( ) Dad ( ) Foster Parent<br>( ) Other _____ | Sex: ( ) Male<br>( ) Female |
| Address (if different than above): | |
| Preferred Phone: | |
| Alternate Phone: | |
| Preferred Email: | |

## Emergency Contact Information

| |
|---|
| Name: |
| Address: |
| Phone: |
| Relationship to Patient: |

## Additional Contacts for Care Coordination

| *Care Provider* | *Contact Information (name, email, phone #)* |
|---|---|
| Primary Physician | |
| Psychology | |
| Teacher | |
| Case Manager | |
| Other | |

## Pregnancy

*Complications during labor/delivery:*

( ) NONE ( ) C-Section ( ) Emergency ( ) Forceps ( ) Vacuum

( ) Other _____

*Complications/Health problems during pregnancy:*

( ) NONE ( ) Diabetes ( ) Toxemia ( ) Strep ( ) Premature Labor

( ) Other _____

Medications during pregnancy: ( ) Yes ( ) No

If yes, please list _____

_____

Drug/Alcohol use during pregnancy: ( ) Yes ( ) No

If yes, please list _____

_____

## Birth Information

| | |
|---|---|
| Birth Weight: _____lbs _____oz | Gestational Age at Birth: |
| APGAR: | |

*Condition After Birth*

( ) Full-Term ( ) Pre-mature ( ) NICU Stay (If yes, duration: _____)

( ) Oxygen ( ) Jaundice ( ) Heart Problems ( ) Feeding Tube

( ) Congenital Abnormalities (If yes, please explain _____

_____)

Other _____

Any Testing Completed _____

_____

## Medical History

Major Illnesses (if any):

( ) Ear Infections (how often? _____ what treatment? _____)
( ) Seizures (how often? _____ what treatment? _____)

Does/did your child use a pacifier or suck their thumb?

Hospitalizations (if any):

Surgeries (with dates):

( ) Ear Tubes _____ ( ) Central Line _____ ( ) G-Tube _____ ( ) Heart Repair _____ ( ) Trach _____ ( ) Shunt _____
( ) Tonsillectomy _____ ( ) Adenoidectomy _____
( ) Frenulectomy _____
( ) Other _____

Allergies: ( ) Yes ( ) No Bad reaction to a medicine or treatment?

If yes, please list:

Tests Performed (if yes, please list date):

( ) MRI _____ ( ) CT Scan _____ ( ) Genetic Testing _____

( ) X-Rays _____ ( ) Other_____

Current Medications (list medication, dosage, and reason):

Has your child ever had a vision test? ( ) YES ( ) NO

If yes, date _____ and results _____

Does your child wear glasses? ( ) YES ( ) NO

Has your child ever had a hearing test? ( ) YES ( ) NO

If yes, date _____ and results _____

Does your child wear a hearing aid? ( ) YES ( ) NO

If yes, please indicate: ( ) LEFT ( ) RIGHT

Has your child ever received services or additional supports (ie. OT, PT, Speech, Early On, IEP/504, tutoring in school, Special Education classroom, Resource Room, pull out groups in school)? ( ) YES ( ) NO

If yes, please list all and explain:

Is your child aware of the problem?

## Developmental History

*Please list the approximate age your child accomplished the following:*

| | |
|---|---|
| Looked at items pointed to/ shared enjoyment of items/activities | |
| Babbled/cooed/blew raspberries | |
| Sat/Crawled/walked independently | *sat:* *crawled:* *walked:* |
| Used the toilet independently | |
| Slept through the night independently | |
| *Any feeding/mealtime difficulties? YES NO*<br>*If yes, please explain (ie. gagging, choking, difficulty swallowing, reflux/vomiting, very picky eater…)* | |
| *What percent of your child's speech do you/others understand?*<br>*You:* *Close family/friends:* *Unfamiliiar people:* | |
| *Tell about how your child:* | |
| Gets your attention | |
| Asks for something | |
| Handles conflict | |
| Tells you "no" | |
| Enjoys reading | |
| Asks questions | |
| Answers questions | |
| Enjoys school | |
| Speaks (smoothly, stutters) | |
| Puts words together (how many?) | |
| Learns new words | |
| Tells a story | |
| *Any family history of speech/language difficulties? YES NO*<br>*If yes, please explain* | |

| Social Emotional – *describe how your child does in the following situations* | |
|---|---|
| Play well with others | |
| Follows directions | |
| Develops peer relationships | |
| Handles strong emotions: (anger, sadness, anxiety) | |

## Educational History

| What school does your child attend? | |
|---|---|
| Grade: | How often does he/she attend:<br>_____ days per week _____ hours per day |
| What are your child's strengths in school? | |
| What areas at school are the most difficult for your child? | |

## What goal would you like your child to work on while with us?

| |
|---|
| |

*Thank you for taking the time to complete this form!*