DYNAMIC SPEECH SERVICES, LLC

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Client and Family Information:

Name of child: _____ Date: _____

Name by which your child is called: _____

Date of birth: _____ Age: _____ Gender: _____

Mother's Name: _____

Father's Name: _____

Address:_____

Telephone # (Home): _____ (Cell): _____

Email Address: _____

Referred by: _____

Additional person (other than guardians) to contact in case of emergency:

_____

Telephone #: _____

Siblings:
Please list-Name/Age/Gender

Does anyone else in the family have speech, language, or hearing difficulties? Yes / No
If yes, please describe:

What language(s) does your child speak and understand?

Birth / Medical History:

Please briefly describe any pertinent birth or current medical history/diagnoses including allergies:

Has your child had his/her tonsils and adenoids removed? Yes / No

Does your child have a history of ear infections / PE Tubes? Yes / No

Has your child's hearing ever been tested? Yes / No
Date of Testing:
Results of Testing:

Speech/Language History:

Has your child ever had speech therapy? Yes / No
If yes, where and when?

Has your child received any other evaluation or therapy services (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? Yes / No
If yes, please describe:

Does your child appear to understand what you say (directions, questions)?

How does your child primarily communicate? (eye contact, gestures, jargon, words, sentences, sign language, AAC device, etc.)

What efforts does your child make to communicate his/her wants and needs when not understood?

Is your child's speech understandable to you? to family? to friends? to strangers?

Please list the age your child acquired each skill or N/A if not yet completed

Skill	**Age**
Babble	
First Word	
Used 2-3 word sentences	
Asked Questions	

Educational/ Social History

Child's school / City: _____

Type of program: _____

Classroom Teacher: _____

Does your child receive assistance and/or special education services at school? Yes / No
If yes, please specify:

List your child's easiest and most difficult subjects/areas:

How does your child interact with other children/siblings?

What are your child's favorite activities, toys, and interests?

Feeding / Oral-Sensory:

Did your child have any feeding problems in early life? Yes / No
If yes, please describe:

Are there any current eating problems? Yes / No
If yes, please describe:

Does your child have difficulty chewing or swallowing? Yes / No

Does your child drool? Yes / No

Is your child a picky eater? Yes / No

Does your child suck his/her thumb or use a pacifier? Yes / No

Did your child suck his thumb or use a pacifier in the past? Yes / No
If yes, at what age did this behavior stop?

What are your child's favorite foods?

Does your child have any food allergies?

Please provide any additional information that you think is important/relevant regarding your child's medical, social/emotional, and academic history:

Please list your primary goals for your child's speech therapy.

Name of person who completed this form: _____

Relationship: _____