All information obtained on this form will be confidential. Patient information is needed for implementing the most appropriate therapy services.

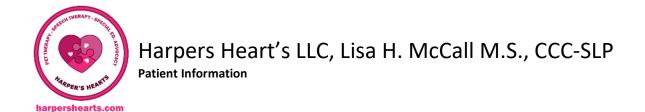
PATIENT INFORMATION: Name: _____ Age: _____ Sex: _____ Date of Birth: ______ Phone (h)_____ Phone (cell)_____ Address: _____ (street number) (city) (zip) Name of school or preschool: ______ Grade: _____ Name of Pediatrician & Practice: Please describe your specific concerns: Please list family members living in the home: ______ Please list any other languages spoken in the home: Was the patient born premature? ______If so, at how many weeks? _____ Describe a typical day for your child (ex: at home, attends daycare, school, etc.): If your child is not yet talking, how does he/she communicate his/her wants and needs (ex: pointing, leading you by the hand, etc):

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MEDICAL AND DEVELOPMENTAL HISTORY:

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List any hospitalizations, surgerie	es, or serious illnesses along with t	he date of occurrence:
Does your child have a history of	ear infections? If so, please expla	in:
Diagon list the approximate and		d the fall accions well asked and
	of your child when he/she achieve	_
babbled	said first words	combined words
crawled	walked	stood
sat up	fed self	toileted
Does your child have any feeding	g difficulties?	
List any medications your child is	s currently taking:	
List any previous screenings or e	valuations your child has received	and when:
Has your child received any prev	ious therapies (if so, please explain	n):
List any diagnosis that has been g	given to your child:	
Does your child currently have a	n IEP/IFSP (if so, please bring to in	itial visit):
Does your child appear to be awa	are of or frustrated by any speech	or language difficulties?



Signed: Date:

Visa, MasterCard, American Express, HSA and FSA Cards, check or cash.)