PATIENT INFORMATION

Child's Name: _____ Date of Birth: _____

Address: _____

Zip:_____ Phone: _____School: _____

Parent/Caregiver's Name: _____ Date of Birth: _____

Occupation: _____ SSN: _____

Phone: (mobile) _____ (work) _____

Email Address: _____

Parent/Caregiver's Name: _____ Date of Birth: _____

Occupation: _____ SSN: _____

Phone: (mobile) _____ (work) _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

Other Children/Adults in Home:

Name	Age	Relationship

Primary home language: _____

Other languages spoken in home: _____

Reason for referral / Primary concern: _____

How did you find us? Physician Friend Insurance Internet School Other_____

Person responsible for payment: _____

HEALTH HISTORY

Person Completing History: _____ Relationship to Patient: _____

Prenatal and Birth History

During this pregnancy and/or delivery, did mother or baby experience any complications? If so, please describe._____

_____

Length of pregnancy: _____ Birth Weight: _____

Has your child ever been hospitalized? Yes No *If yes*, when and describe: _____

_____

Has your child had any other significant illnesses, injuries, or surgeries? *If yes*, when and describe:

_____

_____

Child's current medications: _____

Please list any specific food, medicinal, or environmental allergies: _____

Illness	Age	Severity	Developmental Changes
Pneumonia			
Influenza			
Asthma			
Encephalitis			
Meningitis			
Whooping Cough			
Allergies			
High Fever (104+)			
Ear infections			
Seizures			
COVID-19			

Prior Evaluations

	Date	*Results*
Speech/Language	_____	_____
Occupational Therapy	_____	_____
Physical Therapy	_____	_____
Hearing	_____	_____
Vision	_____	_____
Neurological	_____	_____
Psychological	_____	_____
Other	_____	_____

Please provide previous evaluation reports from other professionals or provide facility and/or name of evaluator to request records. This information may be helpful in assessing and planning of treatment for your child.

Is there any additional information that will help us to better understand your child?

_____
_____
_____
_____

DEVELOPMENTAL HISTORY

Early Development

At what age did your child begin drinking from a cup? _____

At what age did your child begin eating table foods? _____

Does he/she drool? _____

Are there any previous or current feeding concerns/problems? Please explain:

_____
_____

When did your child walk unaided? _____

Has there been any atypical motor development? _____

Please continue onto Page 4 for additional information.

Speech and Language Development

During the first year, other than crying, would you describe your baby as: (circle one)

silent baby quiet baby average noisy baby very noisy baby

Describe your child's first vocalizations/sounds: _____

At what age did your child say his/her first words? _____

Examples of first words: _____

At what age could he/she name most familiar objects? _____

At what age did your child first begin to use two word combinations? (i.e. "want cookie") _____
Examples of two word combinations used: _____

At what age did he/she use complete sentences? (i.e.: "I go outside.") _____
Examples of complete sentences used: _____
_____

Did speech learning ever seem to stop, regress, or change for a period? If yes, explain:
_____

How intelligible is your child's speech <u>to you?</u> (Circle one) 0-25% 25-50% 50-75% 75-100%

How intelligible is your child's speech <u>to others?</u> (Circle one) 0-25% 25-50% 50-75% 75-100%

How does your child ask for what they want?
_____
_____

Does your child give up easily or become easily frustrated when trying to communicate? If yes, explain:
_____

Does your child seem to have difficulty understanding speech? Yes No

Does your child have difficulty following directions? Yes No

School and Social History

Current school/daycare your child attends: _____Current grade: _____

How does he/she get along with peers in an academic setting?

_____

_____

What are his/her usual grades? _____

Has your child ever received any special classroom placement or received remedial help? Please describe:

_____

Does your child receive any speech, occupational, or physical therapy at school? _____

How does your child respond to changes in schedule/routine?

_____

_____

Check the appropriate description(s) of your child's personality:

_____ Outgoing _____ Independent _____ Stubborn _____ Anxious _____ Shy

_____ Dependent _____ Easygoing _____ Aggressive

_____ Other _____

Check the appropriate description(s) of your child's behavior:

_____ Difficult to Manage _____ Noisy _____ Destructive _____ Very Active

_____ Cooperative _____ Quiet _____ Imaginative _____ Talkative

_____ Behavior concerns: _____

Is there any additional information that will help us to better understand your child's communication abilities and/or difficulties?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____