Specializing in the Evaluation and Treatment of Children
with Speech, Language and Learning Challenges

Child's Name ____

Date of Birth ____/_____/_____ Age _________

Today's Date____________________________

Child's Name____

Address ____ City _____________________

State ___________ Zip ________________

Mother's Name ____ Occupation: ______________________________
Father's Name ____ Occupation: ______________________________

Home Phone # (______)___________________________________
Mobile Phone# (______)____________________________________

E-mail ____
Home Fax # (______)___________________________________

Pediatrician: ____ Phone #____________________
Pediatrician's Address: ____________________________________
____

INSURANCE INFORMATION:
Insurance Carrier: _______________________
Insurance ID Number: ___________________
Subscriber Name: ________________________
Subscriber DOB: __________________________

MEDICAL INFORMATION:
Medical diagnosis (if any)____
____

Has your child had a hearing test? : _______no _________yes date_________________
Results: ____

Are there any medical precautions I should be aware of when working with your child? _______________________________
____
____
____
Does your child have any known allergies? ____
____

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Client History

Who Completed this Form? ____

Name and age of child's siblings____

Languages spoken in the home______________________________

Languages your child uses ______________________________

Referral Concerns

What are your major concerns for your child?

____

____

____

What do you wish to gain from this visit?

____

____

____

How does the child usually communicate? (gestures, single words, short phrases, sentences?)

____

____

When was the problem first noticed? By whom?______________________________

____

Has the problem changed since it was first noticed?

____

____

Is the child aware of the problem? If yes, how does he or she feel about it?

____

____

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Are there any other people in your family with speech, language or learning disabilities of any kind, including Hyperactivity or Attention Deficit Disorder? (Please Describe) ____
____
____
____
____

Has your child ever been diagnosed with a condition that affects his/her speech, language, social, or auditory skills? (Down Syndrome, Autism, PDD, Cerebral Palsy, Hearing Impairment, etc.) Yes ______ No _____
Have any other speech language specialists seen your child? Yes ______ No _____
Name of Specialist ____ Date Seen________________
Recommendations____
____

Have any other specialists (doctors, audiologists, psychologists, special education teachers, etc.) seen your child? If yes, please list the type of specialist and date seen.
Name Of Specialist: ___________________________________ Date Seen ______________________
Name Of Specialist: ___________________________________ Date Seen ______________________
Name Of Specialist: ___________________________________ Date Seen ______________________

Prenatal and Birth History

Length of Pregnancy in weeks____________________________________
Birth Weight ____________lbs. _____________oz.
Type of delivery: (circle one) Head First Feet First Breech Caesarian Forceps Assisted
Were there any unusual conditions that may have affected the pregnancy or birth?
____
____
Please describe any other significant health concerns occurring right after birth.
____
____
Is your child adopted? If so, at what age did your child join your family.
____
____
Are you/the parents separated? Yes _____ No _____
Are you/the parents divorced? Yes _____ No _____
Who has legal custody? ____________________________

Medical History

Please answer YES/ NO. If yes, please explain and include approximate age.
Allergies____
Head Injuries____
Hearing Test____
Vision Test____
Ear Infections/Draining Ear____
Mastoiditis____
High Fever____
Hospitalizations____

Medications

Is your child taking any medications? **No / Yes** Explain:
____
____

Sleep History

Describe your child's sleep patterns: (what time, falls asleep easily, etc?)
____
____

Developmental History

Developmental Milestone

Hold up head
Roll over
Sit without support
Crawl
Stand
Walk
Feeds Self
Dress Self
Potty Trained
Tie Shoes
Use first words
Combine 2 words
Combine 3 words
Name simple objects
Use simple questions
Engage in conversation
Does your child have difficulty walking, running, or participating in other activities that require small or large muscle coordination?
____
____

Speech and Language Concerns

Speech

Which areas are of a concern to you about your child? Please include the age at which you first noticed the problem.

-Pronunciation/Articulation: difficult to understand. e.g. says, "tat" instead of "cat."
-Jumbles up sounds in words: e.g. says "colibroc" for "broccoli"
-Stuttering; repeats sounds and words, gets "stuck" e.g. says "b-b-b-b-b-baby" or "doooooooog"
-Rate or speech too fast or too slow
-Difficulty Chewing/Swallowing
-Drools/spits while talking
-Breathe with his/her mouth open
-Has a frequently sound hoarse to his/her voice

Listening

Only repeats questions
Listens to a developmentally appropriate story all the way through
Has difficulty following 1 step directions
Has difficulty following 2 step directions
Has difficulty following 3 step directions
Has difficulty following multi step directions

Educational History

Current School and District: ____ Grade: ______________________
Current Teacher: ____ Phone: _________________________
School Address: ____ Phone: _________________________

Language

Which areas are of a concern to you about your child?
Only uses sounds and gestures to communicate instead of words
Only talks a little
Only repeat things
Jumble words in sentences
Uses incorrect grammar
Can't tell a story from beginning to end
Difficulty answering questions

Pragmatic or Social Language

Relates to peers appropriately
Relates to adults appropriately
Plays cooperatively with others
Negotiates for items or with peers
Has difficulty conversing with peers
Has difficulty understanding body language
Has difficulty taking other people's perspective
Has difficulty making friends
Typical for age____ quiet_____
Outgoing_____ prefers to play alone____

Behavior and Sensory Processing

Bumps into things and falls often
Avoids loud noises or covers ears frequently
Avoids certain food and clothing textures
Has a limited number of dietary choices
Worries a lot
Unusually active for his/her age
Has a shorter attention span than you would expect for his/her age.
Avoids eye contact
Unusually irritable in noisy or crowded places such as malls, parties, etc.
Doesn't respond to his/her name consistently
Has obsessive interests
Displays anxiety
Has periodic screaming fits (beyond typical tantrums)
Any other issues regarding behavior?
Insists on having things their way or a certain way
Difficulty making transitions
Makes repetitive movements such as rocking or flapping
Lines up toys rather than playing with them.

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Special Education Services

Does your child have a 504 plan?
Does your child have an Individualized Education Program (IEP)?
Has your child's school performed a psycho-educational evaluation?
Is your child receiving tutoring or other educational services outside school?
If your child is currently receiving speech-language services through the public schools, would you like us to work in conjunction with the school educational services outside school?
No ____ Yes_____
Did you decline special education services or evaluations that were offered in the public schools for your child?
No ____ Yes_____
For evaluations, may we contact your child's teachers at school for further information as it relates to this assessment?
No___________Yes___________ Please speak to: (include name, phone number, and email)
Is there anyone else you feel we should speak to in order to understand your child better? Please provide the contact information:
____
____
____

Please answer the following questions in reference to your child's educational progress:

Educational Task NO YES
Difficulty writing neatly
Difficulty sounding out words
Difficulty sound letter connections
Difficulty understanding what he/she reads
Difficulty understanding what he/she hears in class

Educational Task NO YES
Difficulty spelling correctly
Difficulty understanding math word problems
Difficulty writing reports or stories
Difficulty remembering instructions for assignments
Difficulty knowing how to study for a test
Difficulty breaking large tasks into smaller pieces

Special Information About Your Child's Interests and Strengths
Describe your child's particular interests. ____
____
What are your child's strengths and talents? ____

What are your child's favorite activities and games? ____

What upsets your child? ____

Tell us about your child's personality.
Please include any other information you think might be valuable.___________________________________
____
____
____
(Feel free to continue on back of page)

By signing below, I accept financial responsibility for all services provided according to Cynthia Moore of In Harmony Speech and Language Services. I understand that the information I am providing to Cynthia Moore, on this form and in any other materials I provide to Cynthia Moore, will be relied upon by Cynthia Moore for purposes of treating my child. I certify to In Harmony Speech and Language Services that the information is true and accurate and that I have the legal authority to provide this information, authorize any requests or permission granted to: In Harmony Speech and Language Therapy and as may be required by In Harmony Speech and Language Therapy for the treatment of my child.

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Print Name ____ Date _____________

Parent / Guardian Signature ____

Relationship to Child ________________________ Child's Name________________________

American
Speech-Language-
Hearing
Association