Children's Therapy Center

Speech Therapy

Today's Date: _____ /_____ /_____

Child's Name: _____

Date of Birth: _____ /_____ /_____ Height: _____ ' _____ " Weight: _____ lbs

How did you hear about us? _____

Emergency Contact: _____

Emergency Contact Phone: (_____)_____-_____ Emergency Contact Relationship: _____

Child's school: _____ Grade: _____

What is the main reason you are seeking help for your child? _____

_____

MEDICAL STATUS

Food or medical allergies: _____

_____

Illnesses currently being treated: _____

_____

Medications presently taken: _____

_____

BACKGROUND

What are your primary concerns regarding your child's communication abilities? _____

_____

Has your child ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

Has your child received speech therapy in the past? ☐ Yes ☐ No

If yes, where and when? _____

Speech Therapy (continued)

BACKGROUND (continued)

Has your child received any other evaluation or therapy (counseling, physical therapy, occupational therapy)? ☐ Yes ☐ No

If yes, describe: _____

Does your child currently have an Individual Education Plan (IEP)? ☐ Yes ☐ No

Is your child aware of, or frustrated by, their speech-language skills? ☐ Yes ☐ No

If yes, explain: _____

_____

What do you see as your child's most difficult challenge at home? _____

_____

List any non-English languages spoken at home: _____

Which language(s) does the child prefer to speak? _____

MEDICAL HISTORY

Has your child ever experienced any of the following?

Adenoidectomy	☐ Yes ☐ No	
Sleeping difficulties	☐ Yes ☐ No	
Tonsillectomy	☐ Yes ☐ No	
Ear tubes	☐ Yes ☐ No	If yes, when: _____
Encephalitis	☐ Yes ☐ No	
Sinusitis	☐ Yes ☐ No	
Frequent colds	☐ Yes ☐ No	
Ear infections	☐ Yes ☐ No	If yes, how often? _____
Seizures	☐ Yes ☐ No	
Thumb/finger sucking	☐ Yes ☐ No	
Allergies	☐ Yes ☐ No	
Head injury	☐ Yes ☐ No	
Vision problems	☐ Yes ☐ No	

Other serious injuries/surgeries: _____

_____

Speech Therapy (continued)

BIRTH

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

If yes, describe: _____

_____

DEVELOPMENTAL

Write the approximate age at which your child achieved the following developmental milestones:

Babbled _____
Said first word _____
Put two words together _____
Spoke in short sentences _____
Sat alone _____
Walked _____
Toilet trained _____

Does your child…

Choke on food or liquids? ☐ Yes ☐ No
Put toys/objects in their mouth? ☐ Yes ☐ No
Brush their teeth and/or allow brushing? ☐ Yes ☐ No

SPEECH, LANGUAGE & HEARING

Does your child…

Repeat sounds, words or phrases over and over? ☐ Yes ☐ No
Understand what you are saying? ☐ Yes ☐ No
Retrieve common objects upon request? (ball, cup) ☐ Yes ☐ No
Follow simple directions? ("Please shut the door") ☐ Yes ☐ No
Respond correctly to who/what/where/when/why questions? ☐ Yes ☐ No

If no to any, describe: _____

_____

Circle one that best describes the manner in which your child currently communicates:

Body language

Sounds (vowels & grunting)

Single word

2-4 word phrases

5+ word sentences

Speech Therapy (continued)

BEHAVIORAL

Circle all characteristics that match your child's current behavior:

Cooperative

Easily distracted

Destructive/aggressive

Prefers playing alone

Poor eye contact

Withdrawn

Inappropriate behavior

Attentive

Separation anxiety

Easily frustrated

Impulsive

Expand: _____

_____

SCHOOL

Is your child having difficulty with any particular subjects? ☐ Yes ☐ No

If yes, describe: _____

What are your child's strengths and/or best subjects? _____

_____

What do you see as your child's most difficult challenge at school? _____

_____