

ABOUT MY CHILD • SPEECH THERAPY

Today's Date: ___ / ___ / ___

Child's Name: _____

Date of Birth: ___ / ___ / ___

Height: ___ ' ___ " Weight: _____ lbs



How did you hear about us? _____

Emergency contact: _____

Phone: () - _____

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? _____

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? _____

BIRTH

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

If yes, describe: _____

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: _____

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

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? _____
