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FOR OFFICE USE:
Allergies:_____
Autopay ❑Yes ❑No

Personal Information

Child's Name: _____ Birth Date:_____
First MI Last

Nickname: _____ Sex: ❑ Male ❑ Female

Mailing Address: _____
Street City Zip

Parent/Guardian:_____
Phone #: _____
Birth Date: _____
Employer: _____
Occupation: _____

Parent/Guardian:_____
Phone #: _____
Birth Date: _____
Employer: _____
Occupation: _____

Email Address: _____

If guardian or either parent's address is different from the child's address, please complete the following:

Relationship to child: _____ Phone #: _____

Address: _____
Street City Zip

Additional Members in Household:

Name:_____ Age:_____ Name:_____ Age:_____
Name:_____ Age:_____ Name:_____ Age:_____
Name:_____ Age:_____ Name:_____ Age:_____

Is there a language other than English spoken in the home? ❑ Yes ❑ No

If yes, which one? _____

What language does the child speak most frequently in the home? _____ at school? _____

Communication Skills Information

What concerns do you have regarding your child's language development or speech and language skills?

❑ lack of babbling
❑ delayed first word
❑ understanding directions
❑ pronouncing words correctly
❑ low vocabulary: how many current words?_____
❑ using incorrect words
❑ grammatical errors
❑ repetitions in sounds and/or words
❑ family history of communication impairments

When did you first notice symptoms?_____

What strategies have been implemented?_____

Additional information or concerns:_____

_____

Medical History

Does your child have any allergies? (latex, food, seasonal, drug) ❑No ❑Yes: _____

Were there any complications: *(if yes, please describe)*
…during pregnancy/birth?

❑No ❑Yes:_____

At what gestation (number of weeks) was your child delivered? _____

…with development of gross/fine motor skills? (ex: sitting up, crawling, walking, self feeding)

❑No ❑Yes:_____

…with breast/bottle feeding skills or transition to solid foods? (ex: choking, gagging, reflux, picky)

❑No ❑Yes:_____

Has your child experienced or been diagnosed with any of the following? *Check all that apply*

- ❑ ADD / ADHD
- ❑ Autism
- ❑ Cerebral Palsy
- ❑ Dental Procedures
- ❑ Developmental Disorders
- ❑ Ear infections / PE tubes
  how often?_____ / when?_____
- ❑ Epilepsy / SeizuresS
- ❑ Head Injury
- ❑ Hearing Loss
- ❑ Heart Problems
- ❑ Hospitalization / NICU
- ❑ Motor Tics / Jerking
- ❑ Serious Accident
- ❑ Serious Illness
- ❑ Tongue / Lip Ties
- ❑ Tonsillectomy / Adenoidectomy
- ❑ Vision Loss
- ❑ Operations / Surgery

Other serious injury/surgery or additional information:

_____

_____

Has your child received prior evaluations or therapies?(ex: educational, psychological, PT, OT, ST)❑No ❑Yes
Type: Location: Dates:

_____

_____

Do you have concerns with your child's hearing or vision? ❑ No ❑ Yes – If *yes*, please complete:

Has your child's hearing been evaluated? ❑ No ❑ Yes:

location/date tested: _____ results:❑Normal ❑Other: _____

Has your child's vision been evaluated? ❑ No ❑ Yes:

location/date tested: _____ results:❑Normal ❑Other: _____

Is your child currently taking any medication? ❑ No ❑ Yes:
Name of Medication(s): Reason: Dates: Noted Side Effects:

_____

_____

_____

Social History

Have there been significant changes in the child's environment that you believe are important? ❑ No ❑ Yes: (ex: family illness, sibling births, deaths, divorce, moves, etc.)

Are there any significant behavior concerns? (ex: aggression, poor attention, repetitive behaviors) ❑ No ❑ Yes:

Does your child get along well with:

Parents? ❑ Yes ❑ No Peers? ❑ Yes ❑ No

Siblings? ❑ Yes ❑ No Adults? ❑ Yes ❑ No

What activities does your child enjoy? (ex: playing outside, sports, watching TV, reading books, favorite toys)

Educational Information

Child's School/ Day Program: _____

Grade/Classroom _____ Frequency your child attends: _____

Is your child enrolled in special education classes?

❑ No ❑ Yes

If *yes*, please circle: PPCD, STEPS, applied/LIFE skills, resource, ST, other:_____

Does your child have an IEP or 504? ❑ No ❑ Yes

Do you have concerns with your child's learning? ❑ No ❑ Yes

If *yes*, please explain:_____

If not enrolled in a day program, how does your child receive daily care?_____

Additional Comments