Patient Name: ______________________ **Date of Birth:** __________ **Date of Eval:** __________

SUBJECTIVE

Why are you seeking Speech Therapy treatment for your child? ______________________________

Do you know of any concerns regarding his/her early speech and language development? □ Yes □ No
If Yes, please describe: ______________________________

Has your child had any prior treatment and/or diagnostic testing for this condition? □ Yes □ No
If Yes, please explain: ______________________________

Does your child currently use an alternative / augmentative communication device? □ Yes □ No
If yes, was the device purchased through insurance? □ Yes □ No
Date of next Doctor's appointment: ______________________________

THERAPIST COMMENTS: ______________________________

CURRENT COMPLAINTS

What are your main concerns regarding your child?

□ Fine Motor (i.e., handwriting, buttoning) □ Mobility □ Feeding □ Behavior
□ Other: ______________________________
□ Gross Motor (i.e., walking, kicking a ball) □ Speech □ Language
□ Other: ______________________________

THERAPIST COMMENTS: ______________________________

PREGNANCY AND BIRTH HISTORY

Were there any complications during pregnancy? □ Yes □ No Comments: __________

Was the pregnancy full term? □ Yes □ No Comments: __________

Were any drugs or medications taken during pregnancy? □ Yes □ No Comments: __________

Was labor and delivery normal? □ Yes □ No Comments: __________

Please list birth weight and length: ______________________________

THERAPIST COMMENTS: ______________________________

GROWTH AND DEVELOPMENT

At what age did your child: (Check all that apply)

□ Roll over from stomach to back? __________ □ Roll over from back to stomach? __________
□ Sit independently? __________ □ Crawl? __________
□ Walk holding onto furniture? __________ □ Walk independently? __________
□ Speak first word? __________ □ Speak in two word sentences? __________
□ Drink from cup? __________ □ Use a spoon? __________
□ Dress independently? __________ □ Toilet train? __________

Please describe your child:

□ Mostly Quiet □ Tires Easily □ Talks Constantly
□ Impulsive □ Overly Active □ Overreacts Frequently
□ Has Temper Tantrums □ Has Poor Attention Span □ Gets Frustrated Easily
□ Difficulty Separating □ Has Nervous Habits □ Has Unusual Fears
□ Difficulty Learning New Tasks □ Happy □ Restless
□ Clumsy □ Shy □ Stubborn
□ Avoids Touch □ Craves Touch
□ Other: ______________________________

THERAPIST COMMENTS: ______________________________

Patient Name: ______________________________ **Date of Birth:** ____________ **Date of Eval:** ___________

PREVIOUS MEDICAL HISTORY

How would you classify your child's general health? □ **Good** □ **Fair** □ **Poor**

Please check ALL that apply

□ Allergies	□ Encephalitis	□ Nausea/Vomiting
□ Asthma/Breathing Difficulties	□ Acid Reflux	□ Ringing of the Ears
□ Bronchitis	□ Fever	□ Seizures/Epilepsy
□ **Cancer**	□ **Head Injury**	□ Sinusitis
□ Chest Pain/Angina	□ Headaches	□ **Stroke/TIA**
□ Chicken Pox	□ Heart Disease	□ Chronic Colds
□ High/Low Blood Pressure	□ Surgeries	□ Thyroid Disease
□ Chronic Laryngitis	□ Hypoglycemia	□ Physical Abnormalities
□ Congenital Defects	□ Measles	□ **Pneumonia**
□ **Depression**	□ Meningitis	□ Tonsillitis
□ Diabetes I or II	□ Metal Implants	□ Whooping Cough
□ Mumps	□ Muscular Dystrophy	□ Tuberculosis

Is there any other information regarding your child's medical history that we should know about?
____
____
____

Does your child have any of the following? **If Yes, please explain in the space provided:**

□ **Cleft Palate/Dental Problems**	□ **Yes**	□ **No**	**Describe:** ______________________
□ **Ear Ache/Ear Infection**	□ **Yes**	□ **No**	**Describe:** ______________________
□ **Hearing Difficulties**	□ **Yes**	□ **No**	**If Yes, Aided?** ______________________
□ **PE Ear Tubes Inserted**	□ **Yes**	□ **No**	**Describe:** ______________________
□ **Vision Problems**	□ **Yes**	□ **No**	**If Yes, Treatment?** ______________________

THERAPIST COMMENTS:
□ **See Attached List**
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EDUCATION HISTORY

Does your child attend school? □ **Yes** □ **No** **If Yes, where?** ______________________________

Has your child ever repeated a grade? □ **Yes** □ **No** **If Yes, what grade(s)?** ______________________

What grade is he/she in? ____________________

Does your child have Special Education or Therapy services <u>in school</u>? □ **Yes** □ **No**

How often?______________________ **How long?**______________________________________

Individual/Group? ____

Additional Comments: ____

____

Has your child received Therapy anywhere else? □ **Yes** □ **No**

If Yes, what services? □ **Physical Therapy** □ **Occupational Therapy** □ **Speech Therapy**

Where? ____

By Whom? ____

Additional Comments: ____

____

Are there any religious or cultural issues that we should be aware of regarding your child's evaluation?
____
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THERAPIST COMMENTS:
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Patient Name: ______________________ **Date of Birth:** __________ **Date of Eval:** __________

COMMUNICATION HISTORY

Please describe any communication difficulties: ______________________________

____

When was the problem first noticed? ______________________________

____

Has there been a change in your child's communication in the last 6 months? □ Yes □ No

If Yes, please explain: ______________________________

____

How does your child communicate at home? (i.e., signs, pictures, verbal, augmentative communication)

____

Was there ever a time when speech or language development seemed to stop? □ Yes □ No

If Yes, please explain: ______________________________

____

How many words are in your child's vocabulary?

Speaking Vocabulary (Expressive)	Words They Understand (Receptive)
□ Under 25	□ Under 25
□ 25-75	□ 25-75
□ Over 75	□ Over 75

Does your child:

□ Understand and follow simple directions?	□ Yes	□ No
□ Answer "Yes/No" questions?	□ Yes	□ No
□ Identify body parts?	□ Yes	□ No
□ Answer "Why" questions?	□ Yes	□ No
□ Recognize pictures of common objects?	□ Yes	□ No
□ Have hearing loss?	□ Yes	□ No
□ Turn his/her head when name is called?	□ Yes	□ No
□ Respond to loud sounds?	□ Yes	□ No
□ Communicate with intent?	□ Yes	□ No
□ Respond to soft sounds?	□ Yes	□ No

Has your child had a hearing evaluation? □ Yes □ No

If Yes, When? __________ **Where?**__________ **By Whom?**__________

Results of hearing evaluation: ______________________________

Has your child had:

□ Changes in hearing during the last 6 months?	□ Yes	□ No
□ Discharge from the ears?	□ Yes	□ No
□ Changes in hearing in the last year?	□ Yes	□ No
□ Pain in the ears?	□ Yes	□ No
□ Balance problems?	□ Yes	□ No
□ Dizziness?	□ Yes	□ No
□ Hearing better on some days rather than others?	□ Yes	□ No
□ Nausea?	□ Yes	□ No
□ Ringing or noise in the ears?	□ Yes	□ No

Other language(s) besides English spoken in the home: ______________________________

THERAPIST COMMENTS:

____

Patient Name: ______________________ **Date of Birth:** ____________ **Date of Eval:** ___________

SOCIAL HISTORY / INTERESTS / LIVING ENVIRONMENT

Father's Name: ______________________ **Age:** ________
Occupation: ______________________

Mother's Name: ______________________ **Age:** ________
Occupation: ______________________

Is child adopted? ☐ Yes ☐ No **If Yes, at what age?** ____________

Parent's Marital Status ☐ Married ☐ Living Together ☐ Separated ☐ Divorced ☐ Remarried

Who lives in the house with this child? ______________________

Has there been any of the following in your immediate or extended family?
☐ ADHD ☐ Learning Disability ☐ Autism/PDD ☐ Hearing Loss ☐ Stuttering

THERAPIST COMMENTS:
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MEDICATIONS

Please list all of the medications (with specific dosages) that your child is currently taking (including over-the-counter, prescriptions, herbals, and vitamins/minerals): ______________________
____
____

THERAPIST COMMENTS:
☐ **See Attached List**
____
____

MEDICAL PRECAUTIONS/CONTRAINDICATIONS

Are there any factors that may complicate your child's ability to participate in Therapy? ☐ Yes ☐ No
If Yes, please explain: ______________________
____

Does your child have food allergies? ☐ Yes ☐ No
If Yes, please list: ______________________

Does your child have any movement restrictions? ☐ Yes ☐ No
If Yes, please list: ______________________

THERAPIST COMMENTS:
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PATIENT GOALS FOR THERAPY

What goals are you hoping to have your child accomplish by participating in Therapy? ______________________
____
____
____

THERAPIST COMMENTS:
____
____

OTHER RELATED INFORMATION

THERAPIST USE ONLY: ______________________
____
____
____
____
____
____

PATIENT GUARDIAN SIGNATURE

To the best of my knowledge I have fully informed you of the history of my child's problem and current status.

Patient Guardian's Signature: ______________________ **Date:** ______________

Relationship to Child: ______________________

THERAPIST SIGNATURE

The above information represents all significant subjective findings.

Please refer to the enclosed Objective Findings and Plan of Care for my assessment, treatment goals, and treatment plan.

Therapist's Signature: ______________________ **License #** ________________ **Date:** ______________

Printed Therapist's Name: ______________________