The Speech Space

Play, Talk, Grow

Today's Date:_____

Identifying Information

Child's Name:_____

Date of Birth: _____ Responsible Party: _____

Relationship to Child: _____

Parent/Caregiver Contact Information:
Name 1:_____ Name 2:_____

Phone 1:_____ Phone 2: _____

Emails:_____

Address:_____

Parent Occupations:_____

Name, Phone, E-mail of Nanny:_____

What is the name of your child's school:_____

Does your child have an IEP?_____
If yes, what services do they receive:_____

Which of the following concern you? (check all that apply)

_____ 1) number of words your child uses in a sentence
_____ 2) your child's pronunciation of words
_____ 3) your child's ability to understand language
_____ 4) your child's play/social skills
_____ 5) your child's eating habits
_____ 6) your child's ability to maintain attention
_____ 7) your child's ability to read
_____ 8) your child's ability to use language to converse (back-and-forth dialogue)
_____ 9) Academics

Please explain: _____

What do you hope therapy will accomplish? _____

Who will implement a speech and language home program?_____

Who recommended that you see a speech-language pathologist_____

How did you hear about The Speech Space? _____

Do you plan on filing for insurance reimbursement? _____ Name of insurance: _____

Birth History

Was there anything significant about the pregnancy or birth? _____
If yes, please explain:_____

Family History

Does your child have any siblings? _____ If yes, what are their ages?_____
What languages are spoken in the home or in any of your child's other settings?_____
Is there a family history of speech and language development disorders or delays? _____
(If yes, please describe)_____
_____
_____
Is there a family history of pyschological or medical diagnosis? ____ If so, please describe
_____
Is there a family history of learning problems? _____ If so, please describe:_____
_____
_____

Medical Information

Pediatrician: _____ Address_____

Has your child ever been given a medical diagnosis? ____If yes, what diagnosis? _____

What was the treatment?_____

Has your child ever suffered from ear infections? _____ If yes, how many? ____ Which ears?_____
At what age(s)? _____ Were PE tubes inserted? _____ If yes, at what age?_____

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Is your child on any medications(specify)_____

Does your child have any allergies(specify)_____

Did your child ever suffer from reflux?_____Were any medications prescribed?_____

List other professionals working with (or who have worked with) your child:

Names/Professions: Phone Numbers:

_____ _____

Has your child been treated by another speech-language pathologist? (Please provide name, telephone number, and reason)_____

Speech and Language Development

Was there anything significant about your child's speech and language development?_____
If yes, explain:_____

How does your child currently communicate?_____

Do you have concerns with your child's speech fluency?_____
If yes, explain:_____

Is your child showing signs of frustration arising from his/her communication?_____

Feeding Development

Was there anything remarkable about your child's early feeding history?_____

Do you have any concerns with your child's eating and/or nutrition?_____
If yes, please explain:_____

Explain your child's typical eating habits:_____

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Feeding Development

Does your child have any food allergies? _____yes _____no _____never tested

If yes, describe._____

Social and Environmental

Does your child interact well with peers? _____ With adults?_____

Does your child make eye contact with others?_____

Is your child sensitive to certain sounds/pitches (e.g., vacuum cleaners, blenders)?_____

Does your child cover his/her ears when he/she hears certain sounds? (specify)_____

Does your child seem under-reactive to loud sounds (e.g., ambulance)?_____

Describe your child's current activity level (low, typical, high)_____

What is your child's current sleep pattern? Sleeps from _____ to _____

What activities does your child enjoy the most?_____

What activities does your child refuse to do?_____

How does your child spend most of his/her time?_____

How much time does your child spend watching television per day?_____

Does your child have difficulty calming themselves?_____

Does your child show back-and-forth communication (e.g., gesture, facial expression, or verbalization) with his/her caregiver? For example, mom smiles at child, child coos, then mom coos and child reaches to be picked up, then mom smiles and then baby laughs._____