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:_____

Does your child attend school, day-care, or other program? (specify name, days attended, and length of day)_____

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)

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

Is birth history and early milestones and development known? _____

If not, please note here (e.g., unknown due to adoption, surrogacy, etc)_____

Were there any complications (e.g., maternal health problems, bed-rest, medications) with the pregnancy? _____
Explain:_____

How long was the mother on bed-rest?_____

Was your child born premature? _____
Please provide details as to difficulties and treatment:_____

Were there any complications during labor and/or delivery (e.g., forceps, vacuum extraction)? Explain:
_____

Apgar scores:_____

Child's birth weight:_____
Was your child admitted to the NICU? _____ If so, explain (include length of stay):_____

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?_____
Does your child have fluid in his/her ears? _____ If yes, for how long?_____
Has your child's hearing been tested? _____ When?_____
Where? _____ What were the results?_____

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

Does your child communicate with gestures? _____ Sounds (e.g., grunts)?_____

At what age did your child begin using one-word utterances?_____

Two-word utterances?_____

Give examples of several phrases your child often uses (e.g., "want milk")_____

Do others understand your child when he/she communicates?_____

Speech and Language Development

Does your child repeat a word or sound within an utterance (e.g., "like like like this one mom")?

_____

How many times does your child repeat the repeated sound or word? Two or less?_____

Three or more?_____

How many times a day does your child repeat a word or sound within an utterance?_____

Is your child repeating sounds, syllables, or words? (Provide examples)_____

How long has your child been repeating sounds, syllables, or words? (Provide approximate dates)

_____

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

Oral-Motor Development

Does your child use a pacifier? _____ At what age did he/she stop?_____

Does your child suck his/her thumb? _____ At what age did he/she stop?_____

Does your child put toys and fingers in his mouth?_____

Does your child drool?_____

Can your child blow bubbles?_____

Can your child blow whistles?_____

Feeding Development

Was your child nursed? _____ If so, until what age?_____

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

Explain your child's typical eating habits:_____

Feeding Development

Does your child crave food? _____ If yes, please list:_____

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

If yes, describe._____

When eating, does your child prefer specific textures (e.g., mushy, crunch), tastes (e.g., sour, sweet, bland) or temperatures (e.g., hot, cold)?_____

What is the texture of the child's stools (liquid/formed/paste)_____

Please provide examples of regularly consumed foods that are:

Mushy _____ Crunchy _____

Chewy _____ Sour _____

Sweet _____ Bland _____

Cold _____ Hot _____

Please describe a typical breakfast_____

Please describe a typical lunch_____

Please describe a typical dinner_____

Please describe typical snacks_____

Does your child drink from an open cup? _____ Use a straw?_____

Does your child eat from a fork? _____ Spoon?_____

Does your child feed him/herself with a fork?_____

Motor Development

At what age did your child begin to crawl? _____ To walk?_____

Describe your child's crawl_____
Is your child left-handed or right-handed?_____

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

What is the child's current sleep pattern? Sleeps from _____ to _____ Naps 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 him/herself?_____

Does your child respond to his/her caregiver with a facial expression, gesture, or vocalization?_____

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._____