Children's Speech and Language Services, *LLC*

Child's Name: ____________________

Birth Date: ____________________

Parent/Gardian(s): ____________________

Street Address: ____________________

Home Phone: ____________________

Work Phone: ____________________

Cell Phone: ____________________

E-mail Address: ____________________

BIRTH HISTORY (please elaborate when necessary)

Were there any complications during pregnancy?

____

____

____

Was pregnancy full term? ____________ Was delivery normal? ____________

Birth weight? ____________ Apgars? ____________

Were there any medical complications at birth?

____

____

____

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Was child discharged home with mother? ____________________

Were there any special concerns during the first weeks of life?

____

____

____

DEVELOPMENTAL HISTORY

Did your child have any feeding difficulties?

____

____

____

Did your child babble? ____________________

When did your child:

Begin to use single words? __________ 2–3 word combinations? __________

What were they? ____________________

Sit independently? __________ Walk? __________

Briefly describe your child's play and/or interests:

____

____

____

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MEDICAL HISTORY

Does your child have a primary medical diagnosis? ______________________________

Made by whom? ____________________ When? ____________________

Has your child had any major illnesses, operations or hospitalizations?

____

____

Did/does your child have frequent ear infections? ______________________________

Were they treated with antibiotics or tubes? ______________________________

When was your child's hearing most recently tested? ______________________________

Where? ____________________ Results? ____________________

Does your child have allergies? ____________ To what? ____________________

Is an Epipen required? ______________________________

Is there any other medical information we should have?

____

____

____

Do we have your permission to contact your pediatrician? ______________________________

Pediatrician's name: ______________________________

Address:____

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FAMILY HISTORY

Has anyone in the family had speech, language or learning difficulties? *(please include siblings, parents, aunts, uncles, grandparents and first cousins)*

____

____

Please list the name(s) and age(s) of all sibling(s):

____

____

Do any siblings receive help in or out of school? ________________________________

What language is spoken at home? ____

GENERAL INFORMATION

Has your child been assessed previously by a speech/language pathologist?
Neuropsychologist? Psychologist? Occupational therapist?
If so, please complete the following table:

By Whom?	When?	Do we have your permission to contact this evaluator?

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How do you think your child is affected by his/her speech/language difficulties?

____

____

____

What are child's most and least favorite activities?

Most:____

____

Least:____

____

Please describe your child's strengths:

____

____

Should we be aware of any behaviors that might arise during our sessions? *(Please describe)*

____

____

Please describe your concerns about your child:

____

____

What do you hope to learn from this assessment or achieve through intervention?

____

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Is there anything else we should know about your child?

EDUCATIONAL HISTORY

Please complete the following table. Grades can be combined if your child received similar supports within the same school.

Grade(s) (Early Intervention, Preschool or play-group, if a toddler)	**School/Program attended**	**Classroom type** e.g. regular education, inclusion class, special education class	**Supports/Services provided and frequency** e.g. an aide, academic support, speech therapy, occupational therapy, physical therapy, counseling

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Additional comments/information:

____

____

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____

____

Your Printed Name: ______________________________

Your Signature: ______________________________

Date Signed: ______________________________

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