Name:____**DOB:**___________

Concerns:
1. What are your current concerns? _______________________________________
____
____
2. When did you first have concerns about your child? _________________________
____
3. What specific skills would you like your child to achieve in therapy? _____________
____
____

Past Medical History

Medical Diagnoses Received:____
Is there any known history of the following the immediate or extended family?

Autism/ PDD	ADHD	Learning Disability
Hearing Loss	Stuttering	Speech/Language Delay

Please explain:
____
____

Pregnancy and Birth History:
If you answer "yes" to any question, please explain in the space provided below.

1. Were there any illnesses, injuries, bleeding, or other complications during your pregnancy? YES / NO ____

2. Was your pregnancy full term? YES / NO (Gestational Age ________________)

3. Was labor and delivery normal? YES / NO

4. What was your method of delivery? VAGINAL / CESAREAN / BREECH

5. Were forceps or suction used? YES / NO

6. Was oxygen or respiratory assistance required after birth? YES / NO

7. Was patient kept in NICU? YES / NO

Feeding History:
If you answer "yes" to any question, please explain in the space provided below.

1. *Do you have concerns regarding your child's feeding habits? YES/ NO*

____

____

2. Has your child experienced any complications with feeding? YES / NO

____

____

3. How was your child fed as an infant? BOTTLE / BREAST
   - Until what age were they fed this way? ___________________

Medical History:
If you answer "yes" to any question, please explain in the space provided below.

1. Please check any and all of the following that your child has experienced.

_____ Chicken Pox	_____ Cleft Lip/ Palate	_____ Tongue Tie
_____ Seizures	_____ Gastroesophageal Reflux	_____ Feeding Tube
_____ Ear Infections	_____ Fluid in the Ears	_____ PE Tubes
How many? _____	_____ Vision Problems	When? _____

2. Is your child currently taking any medications? YES / NO
If yes, please list:

____

3. Does your child have any known food allergies? YES / NO If yes, please list:

____

4. Does your child have any known drug allergies? YES / NO If yes, please list:

____

____

5. Has your child's hearing been evaluated? YES / NO
When: ____
By Whom:____
Results: ____

6. Are there any other precautions, not described above, of which we should be aware? YES / NO

____

____

____

Speech/Language Development:

1. What are your child's primary modes of communication? *Please check all that apply.*

____ Signing ____ Single words ____ Sentences ____ Picture exchange
____ Gestures ____ Short phrases ____ Augmentative device

2. If your child is talking, please indicate at what age your child began to:

________ Babble ________ 2-3 word phrases
________ First word ________ Use words more than gestures

3. Please given an estimate of how many words are in your child's vocabulary.

________ Receptive Language -- Words Understood
________ Expressive Language -- Words Spoken

4. How much of your child's speech do you understand?

10% or less 11-24% 25-50% 51-74% 75-100%

5. How much of your child's speech do others understand?

10% or less 11-24% 25-50% 51-74% 75-100%

6. Does your child demonstrate frustration when he/she is not understood? YES/NO
If yes, please explain in the space below.

____
____
____

Play and Social Skills:

1. When given a choice, does your child prefer to play alone or with others? How does your child interact with others? (e.g., aggressive, cooperative) ALONE / WITH OTHERS

____
____
____

2. Does your child:

- ○Answer questions logically? YES / NO / SOMETIMES
- ○Greet people arriving or leaving? YES / NO / SOMETIMES
- ○Engage in turn taking? YES / NO / SOMETIMES
- ○Initiate conversation? YES / NO / SOMETIMES
- ○Maintain a topic? YES / NO / SOMETIMES
- ○Recall and tell about everyday events? YES / NO / SOMETIMES
- ○Follow one-step directions? YES / NO / SOMETIMES
- ○Does your child engage in eye contact during communication? YES / NO / SOMETIMES

3. What are some of your child's favorite toys and/or special interests?
____
____
____

Education:
1. Does your child attend school or day care? YES / NO
If yes, where? _________________________________How often? __________________

2. What grade is your child in at the present time? _______________________________

3. Please check any services your child currently receives at school.
____ Speech Therapy ____ Tutoring ____Physical Therapy
____ Occupational Therapy ____ Other ______________________________

4. Has your child received therapy in the past? YES / NO Speech / Occupational / Physical / Other
Where: ____
When:____

5. May we communicate with the school therapists to collaborate services? YES / NO
If yes, please list their information on the "Consent for Release" form and provide a copy of your child's most current IEP.

6. Does your child experience any specific challenges in school? YES / NO *If yes, please explain.*

Additional Comments: ____
____
____
____
____