

# Children's Center for Therapy and Learning

This form must be completed and returned prior to the patient's scheduled evaluation time to assist in creating the most effective assessment experience. Please also provide copies of reports from other specialists, including speech-language pathologists, who have evaluated and/or treated your child.

## GENERAL INFORMATION

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male \_\_\_\_\_ Female

Address: \_\_\_\_\_  
Street City State Zip

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

Mother's Level of Education: \_\_\_\_\_ Father's Level of Education: \_\_\_\_\_

Child's Medical Diagnosis: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Fax: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Other Physician's who provide care:

Name	Type of Specialist
_____	_____
_____	_____

## PATIENT HISTORY

Describe in your own words the type of difficulty your child is having: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When was the problem first noticed? \_\_\_\_\_

Is your child aware of the problem?  Yes  No If yes, how does your child feel about it?

\_\_\_\_\_  
\_\_\_\_\_

Is your child in any pain today?  Yes  No If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## FAMILY INFORMATION

SIBLINGS:

Name			
Date of birth	_____	_____	_____
Sex	_____	_____	_____
Grade	_____	_____	_____
General Health	_____	_____	_____



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Physical Disabilities  Yes  No  Yes  No  Yes  No  
 Educational Difficulties  Yes  No  Yes  No  Yes  No

Is there any history of learning, neurological, psychological or hereditary problems in the immediate family or mother/father's families? If so, please describe. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have there been any other pregnancies?  Yes  No

What languages does your child speak (if more than one please indicate the primary language)?  
 \_\_\_\_\_  
 \_\_\_\_\_

## ADOPTION INFORMATION

Is the child adopted?  Yes  No If so, at what age? \_\_\_\_\_

What changes have you seen since you brought your child home? \_\_\_\_\_  
 \_\_\_\_\_

## HEALTH & MEDICAL HISTORY

Has your child ever been examined by any of the following professionals:

PROVIDER	Dates of Exam/Eval	Name of Provider	Currently under Provider's care
Neurologist			<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapist			<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapist			<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech Pathologist			<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychologist			<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic Physician			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiologist			<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Pediatrician			<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Worker			<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavior Specialist			<input type="checkbox"/> Yes <input type="checkbox"/> No
Otolaryngologist (ENT)			<input type="checkbox"/> Yes <input type="checkbox"/> No

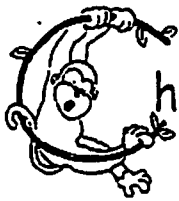
Is your child currently on any medications?  Yes  No

Please list names and schedule of medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What is and has been your child's general health condition? \_\_\_\_\_

Please indicate if your child has had any of the following (if not, please write "NO" in the age column):

Illness	Age	Severity	Hospitalized/ Medication	Illness	Age	Severity	Hospitalized/ Medication
Adenoidectomy				Measles			
Allergies				Meningitis			
Asthma				Mumps			



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Blood Disease				Muscle Disorder			
Cataracts				Nerve Disorder			
Chicken Pox				Orthodontia			
Cleft Lip/Palate				Pneumonia			
Cross Eye				Polio			
Croup				Respiratory Infection			
Dental Problems				Rheumatic Fever			
Diphtheria				Seizures			
Ear Infections				Scarlet Fever			
Encephalitis				Tonsillectomy			
Headaches				Tonsillitis			
Head Injury				Whooping Cough			
Heart Problems				Influenza			
High Fever				Mastoidectomy			
Eczema				Vision Problems			
Anoxia				Reflux			

Other: \_\_\_\_\_

Comments: \_\_\_\_\_

Has your child had any convulsions (seizures)?  Yes  No Age \_\_\_\_\_

Current medication for seizures? \_\_\_\_\_

HOSPITALIZATIONS/SURGERIES	AGE	DURATION	HOSPITAL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe any complications which occurred during any of the above:  
 \_\_\_\_\_  
 \_\_\_\_\_

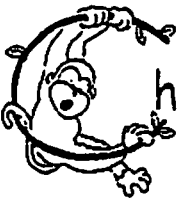
Were any of the above followed by noticeable changes your child's general behavior or in his/her speech? If so, explain: \_\_\_\_\_

**ALLERGIES:**  
 Does your child have any known skin allergies?  Yes  No To Latex?  Yes  No  
 To what? \_\_\_\_\_ Reactions? \_\_\_\_\_  
 Treatment? \_\_\_\_\_

Does your child have any food allergies?  Yes  No Please list: \_\_\_\_\_

Does your child have any allergies to medications?  Yes  No Please list: \_\_\_\_\_

Is your child on a special diet?  Yes  No Please list food restrictions: \_\_\_\_\_



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## CURRENT BEHAVIOR

How would you describe your child (mark all that apply):

- Happy       Easily distracted       Friendly       Imaginative
- Quiet       Cuddly       Aggressive       Tires easily
- Drowsy       Moody       Shy       Curious
- Clumsy       Out-going

Does your child have the ability to (mark all that apply):

- Toilet self       Take care of personal hygiene
- Recognizes clean/soiled clothing       Dress self easily
- Feed self appropriately with manner       Take care of personal belongings
- Structure free time accordingly       Develop good work habits
- Follow rules of games       Involve self in play
- Communicate feelings appropriately       Make appropriate responses
- Problem solve and discuss options with others

Describe your child's strengths: \_\_\_\_\_

Does your child show aversive reaction to touching certain objects or textures?     Yes  No

How does he/she react to familiar touch? \_\_\_\_\_

Does he/she startle easily when touched unexpectedly?     Yes  No

Describe any problems in bowel or bladder control: \_\_\_\_\_

Describe any sleeping problems: \_\_\_\_\_

Is your child a mouth breather?     Yes  No

## PRENATAL & BIRTH HISTORY

Did the mother require medical intervention to achieve pregnancy?     Yes  No

Please indicate if the mother had any of the following during pregnancy?

Condition	Month of Pregnancy	Hospitalization/ Medications	Condition	Month of Pregnancy	Hospitalization/ Medications
<input type="checkbox"/> Excessive vomiting			<input type="checkbox"/> Heart Condition		
<input type="checkbox"/> Bleeding			<input type="checkbox"/> Asthma		
<input type="checkbox"/> Swelling			<input type="checkbox"/> Thyroid Problems		
<input type="checkbox"/> High Fever			<input type="checkbox"/> Kidney Disease		
<input type="checkbox"/> Toxemia			<input type="checkbox"/> X-rays		
<input type="checkbox"/> Rh-Negative Blood			<input type="checkbox"/> Accidents		
<input type="checkbox"/> Seizures			<input type="checkbox"/> Surgery		
<input type="checkbox"/> Virus Infection			<input type="checkbox"/> Alcohol Intake		
<input type="checkbox"/> German Measles			<input type="checkbox"/> Nicotine		
<input type="checkbox"/> Diabetes			<input type="checkbox"/> Drugs		

Was hospitalization required for any of the above conditions?     Yes  No

Were any medication taken during the pregnancy?     Yes  No    Please list: \_\_\_\_\_

\_\_\_\_\_



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Length of Pregnancy \_\_\_\_\_ Duration of labor \_\_\_\_\_ Type of Delivery \_\_\_\_\_  
 Birth weight \_\_\_\_\_ What hospital were you in? \_\_\_\_\_  
 Was your child transferred to another hospital? \_\_\_\_\_ For how long? \_\_\_\_\_  
 Were any drugs or anesthetics used during labor? \_\_\_\_\_  
 Were there any problems with the delivery? If so, please describe \_\_\_\_\_

What was the APGAR rating at the time of birth, if known? \_\_\_\_\_  
 How long did the child remain in the hospital? \_\_\_\_\_

Please indicate if any of the below health problems occurred immediately after birth or during the first 2 weeks of life?

- |  |   |   |                                    |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Jaundiced                       | <input type="checkbox"/> Jaundiced after 2-3 days | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Apnea     |
| <input type="checkbox"/> Seizures                        | <input type="checkbox"/> Intracranial bleeding    | <input type="checkbox"/> Head injury          | <input type="checkbox"/> Tube fed  |
| <input type="checkbox"/> Transfusions                    | <input type="checkbox"/> Feeding difficulty       | <input type="checkbox"/> Scars/bruising       | <input type="checkbox"/> Incubator |
| <input type="checkbox"/> IV fluids                       | <input type="checkbox"/> Unusual muscle tone      | <input type="checkbox"/> Reflux               |                                    |
| <input type="checkbox"/> Surgery (Please explain): _____ |   |   |                                    |

Describe any medical attention mother or child required.

\_\_\_\_\_

Comments: \_\_\_\_\_

## DEVELOPMENTAL HISTORY

Give approximate age of your child in months or years when he/she accomplished the following:

Smiled _____	Looked at your face _____
Followed objects with eyes _____	Held objects _____
Picked up objects _____	Rolled over _____
Sat alone _____	Belly crawled _____
Crept on hands/knees _____	Stood alone _____
Walked _____	Fed self _____
Dressed self _____	Drank from cup/glass _____
Had bowel control _____	Had bladder control _____

## SPEECH & LANGUAGE HISTORY

During the first year, other than crying, how would you describe your child:

A silent baby \_\_\_\_\_  
 A very quiet baby \_\_\_\_\_  
 An average noisy baby \_\_\_\_\_  
 Very noisy baby \_\_\_\_\_

Please describe his/her vocalizations: \_\_\_\_\_

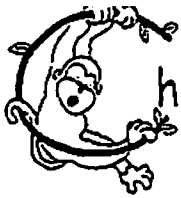
At what age did he/she say his/her first word? \_\_\_\_\_

Did he/she get one or two words and then go a long time before getting any new words?  Yes  No

At what age did he/she use two-word combinations like "want cookie"? \_\_\_\_\_

At what age did he/she use complete short sentences like "I go upstairs"? \_\_\_\_\_

Were these easy to understand?  Yes  No



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What efforts does (or did) your child make to communicate his/her wants when not understood?

\_\_\_\_\_

Did speech learning ever seem to stop for a period?  Yes  No If so, describe: \_\_\_\_\_

How easily can your child follow instructions? \_\_\_\_\_

Do you have to frequently repeat instructions?  Yes  No

Does he/she seem to have any difficulty hearing?  Yes  No

Does he/she have any visual problems?  Yes  No

How easily (poor, fair, good, or excellent (can the child maintain his attention during sitting activities):  
For how long?

Watch TV \_\_\_\_\_

Reading/looking at pictures \_\_\_\_\_

Listening to a story \_\_\_\_\_

What have you done to help your child's speech and language? \_\_\_\_\_

\_\_\_\_\_

## FEEDING DEVELOPMENT/HISTORY

Were there any feeding problems in the early stages?  Yes  No

Please describe: \_\_\_\_\_

\_\_\_\_\_

At what age did he/she start drinking from a glass or cup? \_\_\_\_\_

Describe any present eating problems: \_\_\_\_\_

\_\_\_\_\_

Does he/she have difficulty chewing or swallowing?  Yes  No Does he/she drool?  Yes  No

What does your child eat? \_\_\_\_\_

What does your child not eat? \_\_\_\_\_

How does your child take in liquid?  Bottle  Sippy cup  Straw  Cup  Breast

What types of food does your child eat?

Breast milk  Formula  Baby cereal  Baby food  Table food

Does your child have specific foods that he/she dislikes?  Yes  No Please list: \_\_\_\_\_

\_\_\_\_\_

Where is your child typically fed:  High chair  Booster Chair  Baby seat  Chair

Does your child self-feed?  Yes  No

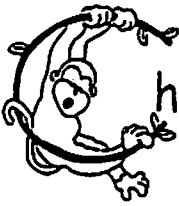
What utensils does your child use independently?  Spoon  Fork  Knife

What is the length of an average feeding/meal? \_\_\_\_\_

Please list any nutritional supplements that your child receives: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## EDUCATIONAL HISTORY

Indicate the type of setting the child was/currently enrolled:

- Home       Home with caregiver       Day care  
 Preschool       Kindergarten       School

List name of current school: \_\_\_\_\_

Grade Level: \_\_\_\_\_

Indicate performance level in school:

- Above average       Average       Below average

List the best/favorite subjects:

\_\_\_\_\_

\_\_\_\_\_

List the most difficult/least favorite subjects:

\_\_\_\_\_

\_\_\_\_\_

Has your child repeated a grade?       Yes  No      Which grades? \_\_\_\_\_

Please indicate any special assistance or services your child receives at school:

SERVICE	YES/NO	NAME OF PROVIDER
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Speech Pathology	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Adaptive PE	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Work	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Aide	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reading Specialist	<input type="checkbox"/> Yes <input type="checkbox"/> No	
LD Resource	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychologist	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	