PATIENT INFORMATION

General Information

Patient Name:_____ Date of Birth_____

Diagnosis (please list all)_____

_____

Name of parent/guardian living in home_____

Names and ages of siblings:_____

Name of school/grade_____

Does your child receive any other speech therapy services? __yes __no; if yes where and the amount per week_____

_____

Developmental History:

Please describe any complications before, during and after the birth

_____

_____

_____

_____

Approximate Age of Developmental Milestones:

Roll_____ Sit _____ Crawl_____

Walk _____ First word_____

Please discuss current status of the following: (ex: wheelchair bound, independent, uses walker)

Mobility_____

Feeding_____

Speech_____

Swallowing_____

Past Medical History/Surgeries- Please list type:(indicate if history of ear infections and frequency)

_____

_____

_____

_____

_____

Vision/Hearing
Last vision and hearing test and results:

_____

_____

Speech:
How does your Child communicate:_____

_____

Describe communication problem: (also indicate if unfamiliar listener's understand your child's communication)_____

_____

_____

_____

List Favorite activities:

_____ _____ _____

_____ _____ _____

_____ _____ _____

What are your goals:_____

_____

_____

Additional information (effect of communication on i.e. behavioral, emotional or socialization challenges) :_____

_____

_____

Your name _____

Today's Date_____