RACHEL CORTESE, MS CCC-SLP, MS Ed

SPEECH, LANGUAGE AND BEHAVIOR THERAPY

SPEECH LANGUAGE HISTORY & BACKGROUND INFORMATION

(Please Print)

Today's date:	Name of person completing form:

IDENTIFYING INFORMATION

Child's last name:	First:	Birth date:	Age:	Sex:
		/ /		❑ M ❑ F

Street address:	City:	Zip:	Mother's cell phone:	Father's cell phone:
			( )	( )

FAMILY INFORMATION

Mother's name:	Father's name:	Mother's Occupation:	Father's Occupation:

Mother's email address:	Father's email address:	Parent's marital status (circle one)
		Single / Mar / Div / Sep / Wid

Does your child receive care from a babysitter/nanny at home?

❑ Yes ❑ No	Name:	Hours:

Who lives at home with your child?	With whom does your child spend most of his/her time outside of school/nursery/daycare?	Names of Siblings:	Age:
❑ Mother ❑ Father ❑ Grandparent ❑ Babysitter ❑ Siblings ❑ Other	❑ Mother ❑ Father ❑ Grandparent ❑ Babysitter ❑ Siblings ❑ Other		

Is there a language other than English spoken in the home?	If yes, which one?
❑ Yes ❑ No	

(OVER)

Who in the family speaks the language?	Does your child speak the language?	Does your child understand the language?	If your child has any words, which language does your child prefer to speak at home?
	❑ Yes ❑ No	❑ Yes ❑ No	

Does anyone in the family have a history of:

❑ Learning problems ❑ Behavior problems ❑ Speech/Language difficulties ❑ Stuttering ❑ Autism	❑ Anxiety or Depression ❑ Selective Mutism (refusal to speak) ❑ Hearing Impairment ❑ Blindness ❑ Tics

If you answered yes for any of the above, please explain:

MEDICAL HISTORY

Primary care doctor:	Doctor's phone number:			
	( )			
Does your child have any allergies?	Medication History:			
❑ Yes ❑ No	Name of Medication	Dates	Reason for Medication	Benefits and side effects

Has your child ever been diagnosed with any of the following?

❑ Learning problems ❑ Behavior problems ❑ Speech/Language disorder ❑ Stuttering disorder ❑ Autism ❑ Selective Mutism (refusal to speak)	❑ Anxiety or Depression ❑ Hearing Impairment ❑ Blindness ❑ Tics ❑ Reflux

If you answered yes for any of the above, please explain:

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Has your child ever sustained a head trauma/injury?
❑ Yes ❑ No

HEARING HISTORY		
Have there ever been any hearing concerns?	Has your child had any ear infections/ congestion requiring medication or tubes?	If you answered yes to either of the previous questions, please describe:
❑ Yes ❑ No	❑ Yes ❑ No	

When was your child's last hearing test?	Where were these tests done?	What were the results?

DEVELOPMENTAL HISTORY	
Duration of Pregnancy (in weeks):	Were there any prenatal complications or complications during delivery? If yes, please explain:
	❑ Yes ❑ No

Developmental Milestones: Please list the approximate age at which your child accomplished each milestone.

Skill	Age	Comments/Concerns
Sat without help		
Crawled		
Walked		
Started babbling		
Used first words		
Named objects		
Put two words together		

Have there been any concerns about your child's growth or development? Please explain.
❑ Yes ❑ No

Has your child lost any skills or abilities? Please explain.
❑ Yes ❑ No

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Do you have any concerns about your child's sleep? If yes, please explain.
❑ Yes ❑ No

EDUCATION HISTORY

Does your child currently attend nursery, daycare or school?			
❑ Yes ❑ No	If yes, where?	Address of nursery/daycare/school:	Phone number of nursery/daycare/school:
			( )

What is the age level/grade of the class?	Type of Program:	Attends how many days/week?	Hours?
	❑ Public ❑ Private ❑ Special Ed ❑ Regular Ed		

If applicable, please check boxes next to special services that your child receives *in school, during the school day*:

❑ Resource Room ❑ Occupational Therapy ❑ Counseling ❑ Adaptive Physical Education	❑ Speech/Language Therapy ❑ Physical Therapy ❑ 1:1 Para ❑ Other _____

Please list all previous daycares, preschools and schools your child attended:

School Name	Dates	Comments?

Has your child ever repeated a grade?
❑ Yes ❑ No

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EVALUATION & TREATMENT HISTORY

Please list all previous *speech and language evaluations*		Please list all *other* previous evaluations (e.g. physical therapy, counseling, occupational therapy, vision, hearing, special education, neurological etc.)	
Agency/ Hospital/ Clinician, etc.	Date:	Type of Evaluation:	Date:

Has your child ever had speech therapy?	If yes, where and when?	
	Where?	When?
❑ Yes ❑ No		

Has your child ever had any other therapy or intervention (e.g. physical therapy, counseling, occupational therapy, vision, hearing, special education)?	If yes, where and when?	
	Where?	When?
❑ Yes ❑ No		

Is your child *currently* receiving any special services outside of school? Please check all that apply:

❑ Speech ❑ Occupational Therapy	❑ Physical Therapy ❑ Counseling	❑ Audiology ❑ Behavioral Therapist or ABA	❑ Special Education ❑ Tutoring

CURRENT COMMUNICATION PROFILE

Describe your main concern about your child's speech and/or language:

When was the problem first noticed? By whom?	Has it changed at all since first noticed? Please explain.
	❑ Yes ❑ No

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Is the child aware of the problem?	If yes, how does he or she feel about it? (e.g. frustrated/ doesn't seem bothered?)
❑ Yes ❑ No	

In what ways does your child currently communicate (check all that apply):

❑ Eye contact ❑ Body movements ❑ Making sounds (e.g. babbling) ❑ Gestures (e.g. pointing, showing, gesturing "up") ❑ Making sounds in combination with pointing? ❑ Using signs/pictures	❑ Using sounds that stand for words (e.g., "brmm" referring to car) ❑ Word approximations ❑ Short phrases (two words or more, e.g. "more juice," "mommy go") ❑ Phrases of three words (e.g., "me more cookies") ❑ Short sentences (e.g. "I want more cookies") ❑ Conversation (talks back and forth with you)

Does your child (check all that apply)...

❑ Repeat sounds, words or phrases over and over? ❑ Seem to understand what you are saying? ❑ Retrieve/point to common objects upon request (ball, cup, shoe)?	❑ Follow simple directions ("Shut the door" or "Get your shoes")? ❑ Respond correctly to yes/no questions? ❑ Respond correctly to who/what/where/when/why questions?

Does your child show interest in the people and things around him/her?

❑ Yes ❑ No

How does your child interact with others?

❑ Shy ❑ Cooperative ❑ Aggressive ❑ Uncooperative	❑ Plays alongside but quietly ❑ Watches other children ❑ Mainly grabs things ❑ Other_____

How does your child usually let you know what he/she wants?

Does your child have any behavioral difficulties (e.g. tantrums, aggressive behavior, extreme shyness, etc.)? If yes, please explain:

❑ Yes ❑ No

Does your child have a history of drooling or feeding problems (e.g. difficulty chewing, swallowing, biting or keeping saliva in his/her mouth)? If yes, please explain:

❑ Yes ❑ No

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Does your child have difficulty saying certain sounds? If yes, please describe:
❑ Yes ❑ No
Do you or anyone else outside the home have trouble understanding what your child is saying?
❑ Yes ❑ No ❑ Sometimes
If your child is talking, does your child stutter, or repeat sounds and words? If yes, please explain:
❑ Yes ❑ No
Do you have concerns about your child's ability to understand vocabulary, answer questions or follow directions? If yes, please explain:
❑ Yes ❑ No
Does your child demonstrate any pre-academic skills (i.e. does he/she know any colors, letters, songs, orient to a book, etc.)?
❑ Yes ❑ No

MISCELLANEOUS

What types of activities does your child enjoy?
Does your child participate in any classes, groups, teams or organizations or take any lessons outside of daycare/nursery/school?

OPTIONAL

Please feel free to use this space to provide us with additional information about particular life events or circumstances that you feel have had a significant impact on your child's communication, development and/or your family.

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IN CASE OF EMERGENCY		
Name of local friend or relative (not living at same address):	Relationship to patient:	Phone no.:
		( )

Please provide copies of any previous evaluations, and if your child is currently receiving any support services, please provide a recent progress report or copy of their most recent IEP.

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