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

Patient'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?

	Name:	Hours:
❑ Yes ❑ No		

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	

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

(OVER)

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

(OVER)

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

Do you have any concerns about your child's sleep? If yes, please explain.

❑ Yes ❑ No

EDUCATION HISTORY

Name of Current School:	Address of School:	Phone Number of School:

What is the age level/grade of the class?	Type of Program:
	❑ Public ❑ Private ❑ Special Ed ❑ Regular Ed

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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 preschools and schools your child attended:

School Name	Dates	Comments?

Has your child ever repeated a grade?

❑ Yes ❑ No

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		

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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?	
❑ Yes ❑ No	Where?	When?

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 SPEECH AND 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
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	

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
Does your child have any behavioral difficulties (e.g. 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
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
Is your child on grade level in school? If no, please explain areas of difficulty:
❑ 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:	Home phone no.:
		( )

If your child is receiving special services, please include copies of any evaluations and your current IEP. Please provide us with a copy of last year's report card.

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