Speech Therapy Marin

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Child's Last Name:____

Child's First, Middle Name:

____

Child's Date of Birth:____________

Child's Grade:________

Caregiver:

Parent Guardian Grandparent Step-Parent Foster Parent

Adoptive Parent

Caregiver's Last, First Name:_______________________________________

Child's Home Address:____

Caregiver's Home Address (or same as above):

____

City:________________________________ Zip:______________________

Cell Phone: ________________ Best times to contact ________________

Current School:____

Male:_____ Female:______

Reason for referral to speech therapy?

____

____

____

Concerns regarding child's lack of academic and/or social/emotional

progress/development?

____

____

____

Child's age when you first noticed problems? _________________________

What educational question(s) would you like the assessment to answer?

____

____

____

Developmental and Family History

Child's Physician	Address	Phone

Date of last: physical examination ____________ hearing screening______________

vision screening ___________

1. Member(s) of Household:

Name	Relationship	Age	Occupation

Language(s) spoken at home: ____

2. Language preferred by child: ____

3. Length of Pregnancy______________ Birth Weight______

Describe pre- and postnatal maternal health and infant's health at birth and during first month:

____

____

____

4. Is there anyone in your immediate or extended family who has had learning problems? If yes, who? Describe the problems they had in school. _______________

____

____

5. How old was child when he or she began to talk? Single words?___________

Sentences? ___________

6. How old was the child when he or she crawled? _____________

Walked?____________

7. Current or chronic health problems (e.g., fatigue, asthma, allergies, seizures, etc.)

____

____

____

8. Is child currently on medication? If yes, type of medication and for what ailment?

____

____

9. Are there nutritional concerns? ____

10. History of illnesses, accidents, hospitalizations: ______________________________

____

____

11. Speech/Language:

Articulation (Sound Production): Late/Missing/Distorted speech sounds?

Please see developmental norms chart to determine if errors are developmental or delayed.

____

____

Percentage of overall intelligibility? ______

Familiar listener?__________

Unfamiliar listener?_________

Receptive Language (Comprehension) strengths/concerns

____

____

____

Expressive Language strengths/concerns

____

____

____

Pragmatic (Social/Emotional) Language strengths/concerns

____

____

____

12. Motor Development: (coordination, gross motor and fine motor activities)

____

____

13. Hearing/ear problems: Yes ____ No_____

Vision or eye problems: Yes ____No _____

If yes, explain: ____

14. Does child need to wear glasses or a hearing aid?___________________________

15. Sleep Disturbances?____

Toilet Problems?____

Weight Problem?____

Nervous Habits?____

16. Describe how your child spends his/her time at home. (How do they play, interests, how active, play alone, with others, both?)

____

____

____

____

____

17. Describe how your child interacts and communicates with siblings, other family members, and with peers. Does your child have difficulty in building or maintaining relationships? Is he/she friendly, active, aggressive, quiet? Does he/she get angry easily or have tantrums?

____

____

____

18. Describe your child's adaptive behaviors i.e., self-care, responsibilities around the home, independent functioning in the community. What does he/she do independently? Dress/undress? Bathroom use? Use of utensils to eat? Behavior in public?

19. Describe any personal traumas or emotional upsets (if any) that appear to be adversely impacting your child (persistent fears, feelings, or behaviors; development of physical symptoms, and/or emotional concerns.)

20. What techniques or methods have been attempted/implemented in your

stated areas of concern?

21. Prior Assessments:

Has your child been tested by another agency? Yes ______ No _______

If yes, please provide the contact information of the person/agency who did the

testing.

Name/Agency:____

Address:

____

____

Phone: ____________________Email: ____

Please provide a copy of any assessment report you have

This will ensure that your child is not over assessed and facilitates the therapeutic process.