Children's Speech Therapy Services, LLC
in-school therapy
in-home therapy

Jennifer Gaum, MA, CCC-SLP
240.426.8401
ChildsSpeech@gmail.com
ChildsSpeech.com

General Information

Child's Name: _____

Address:_____

Date of Birth: _____ Phone: _____

Email:_____

Does your child live with both parents? _____

Mother's Name:_____ Occupation:_____

Father's Name: _____ Occupation: _____

Pediatrician/ number_____

Brothers and Sisters (include names and ages):

_____

What languages does your child speak? What is your child's primary language?

_____

What languages are spoken in the home? What is the dominant language spoken?

_____

With whom does your child spend most of his or her time?

_____

Describe your speech-language concerns (e.g. voice, stuttering, expressive/receptive language delay, social skills, articulation, etc.).

_____

_____

How does your child usually communicate (gestures, single words, short phrases, sentences)? Please give examples.

_____

_____

When was the concern first noticed? By whom?

_____
_____

Has the concern changed since it was first noticed? If yes, explain.

_____
_____

Is your child aware of the problem? If yes, how does he/she feel about it?

_____

Have any other speech-language specialists seen your child? Who and when? What were their conclusions or suggestions?

_____

Have any other specialists (physicians, psychologists, special education teachers, etc.) seen your child? If yes, indicate the type of specialist, when your child was seen, and the specialist's conclusions or suggestions.

_____

Are their any incidences of any of the following conditions among your child's family/ close relatives (maternal and paternal)?

Speech Problems
Hearing Problems
Learning Disabilities Seizures/convulsions
Mental retardation
Autism spectrum disorder
Other

Please describe _____

Prenatal and Birth History

Mother's general health during pregnancy:_____
Length of Pregnancy:_____Birth Weight: _____
General Condition: _____
Type of delivery: head first /feet first /breech/ Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth? (illnesses, accidents, medications, etc.)

_____

Did your child experience any early feeding/swallowing problems (weak suck, turning "blue" while attempting to nurse, projectile vomiting, choking, lack of appetite, early fatigue, milk coming out nose while nursing, etc.)?

_____

Medical History

Provide the approximate ages at which your child suffered these conditions or illnesses (or NA):

Bronchitis _____Croup_____
Ear infections_____German measles_____
High fever _____Measles _____
Pneumonia _____ Tinnitus _____
Vision problems _____Asthma _____
Colds _____Dizziness _____
Encephalitis _____Head injury _____
Mastoiditis _____Mumps _____
Sinusitis _____Tuberculosis _____
Chicken Pox _____Convulsions _____
Headaches _____Influenza _____
Meningitis _____Seizures _____
Tonsillitis _____
Other_____

Has your child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

_____

Describe any major accidents or hospitalizations?

_____

Does your child have any medical diagnoses? (e.g. ADD, autism, dyslexia)?

_____

Is your child taking any medications? If yes, identify:

_____

Have there been any negative reactions to medications? If yes, identify:

_____

Does your child have any known allergies? If yes, identify:

_____

Developmental History & Current Levels

Did your child:

Hold his/her head up by 4 months _____First crawl by 12 months_____
First walk alone by 16 months_____Become toilet trained by 3 years _____
First grasped crayon/pencil (thumb & finger) by 3 years _____
First sit alone by 12 months_____First ate solid food by 12 months_____
Feed self by 2 years_____First use scissors by 3 years_____
Cry normally to communicate pain, fear, discomfort, loneliness_____
Cooing/babbling by 4 months_____
Respond to name/peek-a-boo by 8 months_____

Use jargon* by 12 months _____
Imitate sounds by 12 months_____
Say first word by 15 months_____
Say 2 words together by 24 months_____
Use short sentences by 36 months_____

**Jargon is defined as words that are not understandable, but are said in "sentences" where your child's inflections let you know that he is "saying something."*

Are there or have there ever been any feeding problems (e.g. problems with sucking, swallowing, drooling, chewing)? If yes, describe.

_____

Please describe your child's gross motor skills (coordinated, clumsy, falls a lot, slow, etc.) while walking, running, climbing, riding bikes, roller skating, etc.

_____

Please describe your child's fine motor skills while attempting to color, write, draw, cut with scissors, feed him/herself with utensils, etc.

_____

Describe your child's response to sound (e.g. responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.).

_____

Has your child's hearing been tested previously? If yes, when and what were the results?

_____

Indicate with a checkmark any items that are difficult for your child?

____ Eating a variety of foods
____ Following directions or routines
____ Understanding what he/she hears
____ Speaking in organized or grammatically correct sentences
____ Pronouncing words correctly
____ Answering questions
____ Singing songs/reciting nursery rhymes
____ Stating sounds of letters
____ Recognizing "common" words
____ Rhyming
____ Thinking of words for things
____ Telling stories
____ Receiving/giving hugs
____ Eye-Hand coordination
____ Blowing bubbles
____ Writing his/her name
____ Getting his/her point across
____ Understanding concept of time (seasons, day/night, hours)
____ Self-calming
____ Keeping shoes on
____ Using a straw
____ Keeping hands to him/herself

Behavioral History

Please check all that describe your child:

__ Friendly
__ Impulsive/impatient
__ Easy-going
__ Sleeps well
__ Hyperactive
__ Defiant

__ Aggressive/destructive
__ Stubborn
__ Poor eye contact
__ Grinds teeth
__ Withdrawn
__ Shy
__ Daydreams often
__ Plays well with other children
__ Cannot easily shift from one activity to another
__ Uses pacifier/sucks thumb
__ Plays alone for reasonable amount of time
__ Will not touch certain textures
__ Distractive/short attention span

Educational History

Does your child attend school, day-care, or other program? (specify school name, days attended, and length of day)

_____

Grade: _____ Teacher(s):_____

Does your child receive special services? If yes, describe_____

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals.

_____

How is your child doing academically (or pre-academically)?

_____

Describe your child's current activity level (low, typical, high).

_____

What is your child's current sleep pattern?

Sleeps from _____ to _____ Naps from_____to_____

What activities does your child enjoy the most?

_____

What activities does your child refuse to do?

_____

How does your child spend most of his/her time?

_____

How much time does your child spend watching television per day?

_____

Does your child have difficulty calming him/herself?

_____

Does your child respond to his/her caregiver with a facial expression, gesture, or vocalization? Y / N

Does your child show back-and-forth communication (e.g., gesture, facial expression, or verbalization) with his/her caregiver? For example, mom smiles at child, child coos, then mom coos and child reaches to be picked up, then mom smiles and then baby laughs). Y /N

Which of the following concern you? (circle all that apply) your child's pronunciation of words

1. number of words your child uses in a sentence
2. your child's ability to understand language
3. your child's play/social skills
4. your child's eating habits
5. your child's ability to maintain attention
6. our child's ability to read
7. your child's ability to use language to converse (back-and-forth exchanges)

Please explain.

_____

Please check all that apply:

__Poor memory __Cooperative __Difficulty sleeping ___Unpredictable
___Doesn't like to be read to __Attentive __Clumsy __Talkative
__Has temper tantrums __Has nightmares __Bites nails __Bad tempered
__ Cries easily __Easily frustrated __Restless __Quiet __Eats well
__Doesn't like to be touched __Overly sensitive/ emotional
__Willing to try new activities __Will not eat certain textures __Wets bed
__Mouth breather __Snores __Sensitive to sounds

How does your child interact with others (e.g. shy, aggressive, uncooperative, etc.)?

_____

Is your child repeating sounds, syllables, or words? (Provide examples)

How long has your child been repeating sounds, syllables, or words? (Provide approximate dates) _____

What do you hope therapy will accomplish?

Who will implement a speech and language home program?

Who recommended that you see a speech-language pathologist?

How did you hear about Children's Speech TherapyServices, LLC?

Have any immediate family members been diagnosed with autism?

Have any extended family members been diagnosed with autism?

What are your child's strengths?

What are your child's favorite toys/activities?

What is one goal you'd like to see your child accomplish in the next 6 months?

What about the next 2-3 years?