You are scheduled for a speech/language evaluation on_____at_____
Please complete and bring this form with your insurance card, and any other evaluation reports.

HEARING AND SPEECH CENTER
of Northern California

1234 Divisadero Street, San Francisco, CA 94115
Voice: (415) 921-7658 **Fax:** (415) 921-2243

Child's Name_____Name child usually called_____
Date of Birth_____ Age_____
Street_____City_____Zip_____
Home Phone Number_____
Name of parent 1_____Age_____
Name of parent 2_____Age_____
Parent's status:
Married____Separated_____Divorced_____Deceased_____Single_____Domestic partners_____

Parent 1
Occupation_____
Employer_____
Work Phone_____
Cell Phone _____

Parent 2
Occupation_____
Employer_____
Work Phone_____
Cell Phone_____

How many children are in the home? Boys_____Ages_____
Girls_____Ages_____
Language(s) spoken at home_____
Who is the primary caretaker of your child?_____
What language(s) does he/she speak?_____
Please describe your primary reason for bringing your child for evaluation or therapy (i.e. specific concerns and goals)_____
Who referred you?_____

Birth and Health History

Was this child adopted? _____ If yes, at what age did the child join the family?_____
Full term pregnancy? Yes _____ No_____Explain_____
Normal delivery?Yes_____No_____Explain_____
Did this child go home with parent ?_____If not, how long was child's stay in the hospital?____
Were there special needs for this child at birth? (oxygen, transfusion, incubation)_____
_____
Weight at birth _____ History of jaundice?_____
Is your child presently taking any prescription medication?_____
Name of medication_____Purpose of medication_____
Any major illnesses or surgery to date? No_____ Yes_____Explain_____
_____
Any history of seizures? _____Any history of tonsillitis? _____

Known vision problems?_____
Allergies? (food, environmental, drug etc.)_____
How are the allergies managed?_____
Does your child snore?_____Breathe through the mouth?_____
Is there a history in the family of speech, language or learning disabilities of any kind, including hyperactivity or Attention Deficit Disorder? _____ Explain_____
_____

Medical Evaluations and Treatment

Who is your child's primary physician?_____
Names of other physicians or specialists who have seen this child: (e.g. neurologist, psychologist, social worker, physical therapist, occupational therapist)_____
_____
_____
Has your child previously been diagnosed with a particular condition that would affect his or her speech, language or auditory skills (e.g. Down Syndrome, Autism, PDD, Cerebral Palsy, ADHD)?
_____
Type of previous evaluations:_____
What were their recommendations?_____
_____

Developmental Milestones

At *what age* did your child:
Sit alone?_____
Stand without support?_____
Walk independently?_____

Is your child toilet trained?_____Has toilet training been difficult?_____
Does your child seem awkward when walking or moving?_____
Tends to use: Right hand _____ Left hand_____ No preference yet_____

Speech/Language Development

Were there any early feeding difficulties? _____Explain_____
Was your child bottle fed?____Breast fed?_____For how long?_____
Does/did your child use a pacifier?____Since when/for how long?_____
About how many words does s/he understand?_____If fewer than 25, please list:_____
_____
Can you understand what s/he says?_____Can other adults?_____Can children?_____

At *what age* did your child:
Babble_____
Say first words?_____
Put two words together?_____(for example "more juice")
Say three to four word phrases and sentences?_____
Give an example of a sentence your child would say:_____
_____

How does your child communicate? (Talks, gestures, points, cries, etc,)_____
_____
Does your child have difficulty expressing ideas or experiences?_____
Explain_____
Has your child been evaluated or treated for a speech, language or auditory problem?
Yes_____ No_____If yes, when and by whom?_____
Result:_____

Hearing and Understanding

Do you suspect your child has a hearing problem?_____
Does your child respond to any sounds?_____Explain_____
Does your child appear confused in noisy places?_____
Does your child's listening vary?_____Explain_____
Does your child confuse/forget directions, assignments, requests?_____
Does your child follow directions: With speech only?_____With gestures only?_____ With speech and gestures combined?_____
Has your child had a thorough hearing evaluation by an audiologist? Yes _____ No_____
If yes, when and by whom? _____
Result:_____
History of ear infections?_____ At what age?_____How frequent?_____
Last episode?_____Ventilation/PE
tubes?_____

School History

Is this child in daycare?_____Preschool?_____After school care?_____
Name of School_____ Grade_____
Address of School_____Teacher_____
Is this child receiving special tutoring?_____ In a special day class?_____
Does your child have an IEP/IFSP through the public schools?_____
Date of last IEP/IFSP_____
Did you decline special education services or evaluations that were offered in the public schools for your child? Yes _____ No_____

Social Interaction and Behavior (check all that apply)

_____Typical for age
_____Behavior is consistent
_____Easy to manage
_____Quiet
_____Outgoing
_____Tends to prefer playing alone
_____Seems to have low-self esteem
_____Is unusually active for his/her age
_____Easily distracted
_____Easily frustrated
_____Seems restless or unable to stay with an activity

_____Has a shorter attention span than you expect for his/her age
_____Avoids eye contact
_____Is disinterested in other children
_____Is unusually irritable in noisy or crowded places such as malls, parties, etc.
_____Often repeats phrases heard out of context
_____Doesn't respond to his/her name consistently
_____Has obsessive interests
_____Displays anxiety
_____Short temper
_____Can be violent or unusually physically aggressive
_____Plays primarily by self
_____Plays with children in the family
_____Plays with children outside the family
_____Playmates are younger_____older_____same age_____
Any other issues regarding behavior?_____
What are your child's favorite activities and games?_____
What upsets your child? _____
Tell us about your child's
personality_____
(If you need more room, please continue on the back of this paper)

What areas below concern you at this time (Check all that apply)
___Doesn't talk yet
___Talks very little
___Repeats things
___Doesn't point to pictures in books when requested
___Doesn't relate to people
___Pronunciation
___Chewing/swallowing/drooling
___Answering questions
___Understanding language
___Following directions
___Learning new words
___Remembering what was said
___Listening with background noise
___Social language use
___Understanding idiomatic expressions/inferences
___Putting grammatical sentences together
___Explaining what happened
___Reading (sounding out words) _____Spelling (if 7 or older)
___Reading comprehension (if 7 or older) ___Writing (if 7 or older)
___Stuttering-like speech
___Voice quality
___Other

Personal Characteristics

Does your child have any mannerisms or habits? (Rocking, banging head, pulling or picking at ears, staring at lights or objects, thumb sucking, nail biting, etc.)

_____

What foods does your child like?_____

Child's bedtime?_____Does this child nap?_____

What other information do you think is important for us to know?_____

_____

Who completed this form?_____Date_____