Dana Rimer Speech Therapy
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GENERAL INFORMATION:
Child's Name: ______________________________
Address: ______________________________
____
DOB: ________________

Parent's Names: ____________________________
Home Phone: ______________________________
Mother's Cell: ______________________________
Father's Cell: ______________________________
Email: ____________________________________

Names of Brothers, Sisters, Pets, or other close friends and family members:
____
____

Pediatrician's Name: _________________________
Pediatrician Address: ________________________
____
Pediatrician Phone: __________________________

INSURANCE INFORMATION:
Insurance Carrier: ______________________
Insurance ID Number: __________________
Subscriber Name: ______________________
Subscriber DOB: _______________________

MEDICAL INFORMATION:
Medical Diagnoses (if any): ____
____

Has your child had a hearing test: ____ no _____ yes date ____________
Results: ____

Has your child had any of the following?

	No	Yes	Date	Additional Info
Childhood Illnesses				
Major Illnesses				
Congenital Abnormalities				
Surgery				
Serious Injury				
Ear Infections				
Tubes in Ears				
Allergies				
Seizures				
Other				

List any medication your child is currently receiving and any side effects that you feel impact alertness and communication

____

____

____

Are there any medical precautions I should be aware of when working with your child?

____

____

____

____

Has your child received any other evaluations or treatment? Please list the professional's name and the dates of service.
Neuropsychological

Neurological

Psychological

Occupational Therapy

Physical Therapy

Speech Therapy

MOTHER'S HEALTH DURING PREGNANCY
Any infections/illnesses?

Any shocks or unusual stress?

Any medications received during pregnancy?

Any complications during labor or delivery?

CHILD'S BIRTH
Is your child adopted?
Was your child premature?
Were there any birth injuries?
Was intensive care required?
Apgar ratings if known?

DEVELOPMENTAL MILESTONES: provide ages and comments if any
Rolling over:
Sit alone:
Crawl:
Walk:
Chew solid food:
Drink from a cup:
Say Words:
Say sentences:

SPEECH AND LANGUAGE:

How does your child communicate? Please circle all that apply.

Speech facial expressions gestures

AAC device manual signs pointing vocalizes

physically gets items him/herself brings caregiver to item

What does your child use most often?

____gestures ____sounds ____1 or 2 words ____phrases ____complete sentences

Any adaptive equipment?

Please provide an example of a typical word/phrase/sentence that your child currently uses: ____
____

How often does your child use speech?

____frequently ____sometimes ____rarely ____never

SOCIAL SKILLS:

Does your child:

- Have difficulty making friends?
- Tend to prefer playing alone?
- Have a strong desire for sameness and routine?
- Tend to crave attention?
- Seem sensitive to criticism?
- Lack self-confidence?
- Have strong outbursts of anger, tantrums?
- Have trouble getting along with other children?
- Tend to be quiet or withdrawn?
- Lack carefulness or is impulsive?
- Tend to be intense, easily frustrated?
- Tend to have difficulty separating from caregiver(s)?
- Prefer the company of adults to children?
- Prefer playing with children who are 1 to 2 years younger?
- Seem discouraged or depressed?
- Deal poorly with unstructured time?
- Prefer playing with older children?

Comments: ____
____
____
____

PLAY SKILLS:

What are your child's favorite playthings?

What does he or she do with these toys?

What activities does your child least enjoy?

How long does your child play with one toy?

Are there any things which your child fears or avoids? Please explain.

Does your child seem repetitive and inflexible?

What extra-curricular activities is your child involved in?

FAMILY HISTORY:

Is there a history of speech and language disorders in your family?

Do you or anyone in your family have similar communication challenges to your child's?

Do any of your family members have a diagnosis of Asperger's Disorder, Autism, or Pervasive Developmental Disorder (PDD)?

TELL ME MORE:

How long have you been concerned about your child's speech and language skills?

What made you feel concerned at that time?

What would you most like to gain from this evaluation?

What particular skills would you like your child to develop?

Signature: ____________________Date: ___________Relationship: ________________