SPEECH AND LANGUAGE EVALUATION:

Patient Name: ______________________________	Age: ______________________________
Preferred Name: ____________________________	Pronouns: ________________________
Caregiver's Name: ______________________________	Relationship: __________________________
Email Address: ______________________________	Phone Number: _______________________
Caregiver's Name: ______________________________	Relationship: __________________________
Email Address: ______________________________	Phone Number: _______________________

Environmental History:

Lives with mother/father/aunt/uncle/grandmother/grandfather/Other: _______________________________

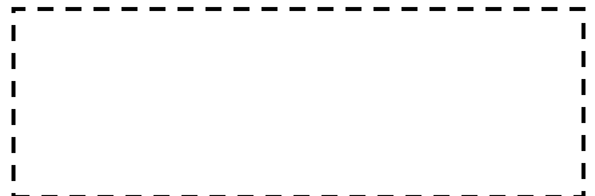
Brothers _____________Ages______________	Sisters ____________Ages______________
Additional Caretakers? Y/N	Screen time per day?
History of speech and language disorder in the family? Y/N	Other languages spoken in the household? Y/N

Birth History:

Birth: Vaginal/C-section (emergency/elective)	____________weeks gestation
Age of mother ____________	____________days in hospital
Other ____________	Complications? Y/N NICU? Y/N

Birth Complications:

☐ Placenta problems	☐ Prolonged/difficult labor
☐ Aspiration (meconium/fluid)	☐ Respiratory distress signs/syndrome
☐ Jaundice (yellow)	☐ Small for gestational age
☐ Umbilical wrap	☐ Fetal distress
☐ Supplemental oxygen	☐ Resuscitation



SPEECH AND LANGUAGE EVALUATION:

Medical History:

Hospitalizations/Surgeries/Illness/Diagnosis? Y/N

Medications? Y/N

Current:

Past:

Seen by specialists? Y/N

- ☐ Neurology
- ☐ Gastroenterologists (GI)
- ☐ Otolaryngologist (ENT)
- ☐ Audiology (AUD)
- ☐ Allergist
- ☐ Optometrist/ophthalmologist

Check any of the conditions your child has/had experienced? (*check all that apply)*

- ☐ Adenoidectomy
- ☐ Tonsillectomy
- ☐ Lip/tongue/cheek release (frenulectomy/frenectomy)
- ☐ Breathing difficulties
- ☐ Sinusitis
- ☐ Allergies
- ☐ Sleeping difficulties
- ☐ Snoring
- ☐ Constipation
- ☐ Diarrhea/loose stool
- ☐ Feeding problems
- ☐ Feeding Tube
- ☐ Reflux
- ☐ Thumb sucking/pacifier use
- ☐ Hearing problems
- ☐ Frequent ear infections
- ☐ Ear tubes
- ☐ Vision problems
- ☐ Head injury
- ☐ Heart conditions
- ☐ Seizure
- ☐ Stroke
- ☐ High fevers
- ☐ Measles/Meningitis/Mumps

Educational History:

Attends: public school/private school/day care/preschool/home school/none

Hours Attended:

Current Educational Accommodations: 504/IEP/None

Modified Curriculum? Y/N
Sensory Supports? Y/N

Previous Evaluations/Treatments:

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Behavior Therapy (ABA)

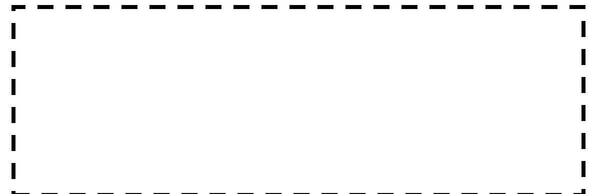
School/Additional Services:

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Behavior Therapy (ABA)

Developmental History: *(note age at which the following were achieved)*

Sat up: ___________________________________
Crawled: ___________________________________
Walked: ___________________________________
Toilet trained: ___________________________________

Babbled: ___________________________________
First Word: ___________________________________
Two words together: _________________________
Sentences: ___________________________________



SPEECH AND LANGUAGE EVALUATION:

Speech and Language:

Does your child currently communicate by: *(check all that apply)*

- ☐ Body language
  - ☐ Sign
  - ☐ Gesture
  - ☐ Pointing
  - ☐ Pulling
  - ☐ Reaching
- ☐ Sounds (vowels, grunting)
- ☐ Words
  - ☐ Single Words (ball, shoe, dog)
  - ☐ 2 word phrases (see dog, have shoe, want ball)
  - ☐ 2-4 word phrases/sentence
  - ☐ Sentence longer than 4 words
- ☐ Other: _________

Does your child....

- ☐ Become frustrated by speech/language difficulties?
- ☐ Repeat sounds/words/phrases over and over?
- ☐ Understand what you are saying?
- ☐ Retrieve/point to common objects upon request (ball, cup, shoe)?
- ☐ Respond to yes/no questions?
- ☐ Follow simple directions (shut the door, get your shoes)?
- ☐ Respond correctly to who/what/when/where/why questions?

Behavior Characteristics *(check all that apply)*

- ☐ Cooperative
- ☐ Attentive
- ☐ Willing to try new activities
- ☐ Plays alone for reasonable length of time
- ☐ Separates easily
- ☐ Easily frustrated/impulsive
- ☐ Stubborn
- ☐ Restless
- ☐ Poor eye contact
- ☐ Short attention span
- ☐ Destructive/aggressive
- ☐ Withdrawn
- ☐ Inappropriate behavior
- ☐ Self-harm behaviors (head banging, pulling hair, hitting self)
- ☐ Arm flapping
- ☐ Toe walking
- ☐ W-sitting
- ☐ Full body flexions

Speech and Language Concerns:

Feeding:

Breastfed? Y/N till _____months ______oz/day

- ☐ Breastmilk
- ☐ Formula
- ☐ Milk

Bottle Fed? Y/N till ____ months ______oz/day

- ☐ Breastmilk
- ☐ Formula
- ☐ Milk

Feeding tube Y/N

Meal time completion: ______minutes

Eating food consistency? Pureed/ground/chunky/table food

Eating with? Finger/fork/spoon/knife

Drinking from? Bottle/sippy up/straw/open cup

Feeding Concerns:

OFFICE USE ONLY:

Frequency: weekly – biweekly – monthly

Duration: _______ Sessions – authorization period