Personal Information

Name of child: (first) _____ (MI) _____ (last) _____

Date of birth: _____ - _____ - _____ Age: _____ Gender:_____

Ethnicity: _____ Primary Language: _____

School: _____ Grade: _____

Your Name: (first) _____ (MI) _____ (last) _____

Your relationship to child: _____

Who is the child's primary care doctor? _____

A. Your Experience & Insights

1. What are your chief concerns about your child? _____

_____
_____
_____
_____

a. When did you first notice these concerns? _____
b. Who else have you seen for these concerns? (Please provide copies of existing evaluations)
_____
_____
_____
_____

c. What has already been done to treat these concerns? (Medications, diet, counseling)
_____
_____

d. What seems to help the most? _____
_____
_____
_____
_____

2. Please tell us about your child's most outstanding characteristics, hobbies, abilities, and/or any other strengths: _____
_____
_____
_____
_____

3. What have you told your child about this visit to Big Apple Speech Therapy? _____
_____
_____
_____
_____

B. Birth History

1. During the pregnancy, did the biological mother have: (please check all that apply)

- ◯ None
- ◯ Anemia
- ◯ Diabetes
- ◯ Premature labor
- ◯ German measles
- ◯ High blood pressure
- ◯ Vaginal infections
- ◯ High fevers
- ◯ Family stress
- ◯ Emotional problems
- ◯ Excessive weight gain
- ◯ Kidney problems
- ◯ Vaginal bleeding
- ◯ Other infections
- ◯ Amniocentesis
- ◯ No prenatal care
- ◯ Exposure to toxins (paint, solvents, toluene, etc.)

a. Please comment briefly on any checked response(s): _____
_____
_____
_____
_____

2. Were any fertility treatments used in this pregnancy? _____
a. If yes, please describe: _____
_____

3. During the pregnancy, did the biological mother use:

◯ Medications ◯ Street drugs ◯ Alcohol ◯ Tobacco

a. Please comment briefly on any checked response(s): _____
_____
_____

4. During the delivery, was anesthesia used? _____
a. If yes, what type? _____
5. Was labor induced? _____

a. If yes, by what? _____
6. How long did the pregnancy last? (months) _____
7. How long was the labor? (hours)_____
8. What was the baby's birth weight? _____lbs _____oz.
9. Baby was born: _____Vaginally _____Caesarean section
10. Did the baby have: (please check all that apply)

- ◯ None
- ◯ Blood transfusion
- ◯ Resuscitation
- ◯ Jitteriness
- ◯ Trouble breathing
- ◯ Birth defects
- ◯ Cord around neck
- ◯ Fevers/low temp
- ◯ Trouble sucking
- ◯ Physical injuries
- ◯ Yellow jaundice
- ◯ Twin
- ◯ Seizures
- ◯ Intensive care

a. Please comment briefly on any checked response(s): _____
_____
_____
11. How long did the baby stay in the hospital? _____
12. Were there any other concerns or issues during this pregnancy or birth not covered by the above questions? _____
_____
_____
13. Was the baby:
a. Breast fed _____Yes _____No If yes, how long? _____
b. Bottle-fed _____Yes _____No
c. Any early feeding problems? _____Yes _____No If yes, explain:
_____
_____

14. What is the pregnancy history of the biological mother?
a. How many previous pregnancies? _____
b. How many previous pregnancies to term? _____
15. Please list any other problems or concerns on the part of the parents or doctors:
_____
_____
_____
_____

C. Medical History

1. Does your child have any: (please check all that apply)

a. Sleep problems

- ◯ None
- ◯ Falling asleep
- ◯ Sleepwalking
- ◯ Excessive Snoring
- ◯ Excessive Sleeping
- ◯ Staying asleep
- ◯ Nightmares
- ◯ Teeth grinding

b. Brain disorders

- ◯ None
- ◯ Coordination difficulties
- ◯ Head injury
- ◯ Headache
- ◯ Motor/vocal tics
- ◯ Tremors
- ◯ Muscle weakness
- ◯ Unusual movements
- ◯ Seizures
- ◯ Fainting spells
- ◯ Confusion
- ◯ Staring spells

c. Lung problems

- ◯ None
- ◯ Asthma
- ◯ Short of breath
- ◯ Coughing

d. Skin disorders

- ◯ None
- ◯ Acne
- ◯ Birth marks
- ◯ Hair loss
- ◯ Eczema

e. Blood disorders

- ◯ None
- ◯ Anemia
- ◯ Bruising
- ◯ Bleeding

f. Heart problems

- ◯ None
- ◯ Chest pain
- ◯ Congenital heart
- ◯ Surgery

g. Sexuality

◯ Normal ◯ Menstruation _____ yr _____ mo ◯ Birth control
◯ Masturbation excess ◯ Promiscuity

h. Kidney problems

◯ None ◯ Reflux ◯ Bladder infection
◯ Infections ◯ Bedwetting

i. Muscle and bone problems

◯ None ◯ Spasticity ◯ Low tone
◯ Scoliosis ◯ Injuries

j. Allergies

◯ None ◯ Environmental
◯ Seasonal ◯ Food

k. Gland problems

◯ None ◯ Fast growth ◯ Slow growth
◯ Obesity ◯ Early puberty ◯ Thyroid problem
◯ Delayed puberty

8. Please list all current and past supplements, remedies, nutriceuticals, or vitamin products that this child takes.

Age Start – Stop	**Medicine**	**Doctor**	**Reason**	**Currently Taking**
_____-_____	_____	_____	_____	Yes/No
_____-_____	_____	_____	_____	Yes/No
_____-_____	_____	_____	_____	Yes/No

_____-_____ _____ _____ _____ Yes/No

_____-_____ _____ _____ _____ Yes/No

a. Please list any special diets your child follows: _____
_____
_____

9. Do you have any concerns about your child's diet? Yes/No
a. If yes, what are they? _____
10. Please list any special diagnostic tests (X-Rays, EEG, MRI, CT scan, blood tests, hearing test) your child has undergone.

Age	Test	Reason	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

11. Most recent hearing screen? Date _____-_____-_____ Pass/Fail
12. Most recent vision screen? Date _____-_____-_____ Pass/Fail
13. Have you ever suspected child was physically/sexually abused? Yes/No
a. If yes, please explain:
_____
_____
_____

14. Is your child left or right handed? Left/Right

D. Early Development

1. At about what age did your child first:

a. Sit up?	**Age _____**	**On time/Early/Late**
b. Crawl?	**Age _____**	**On time/Early/Late**
c. Stand alone?	**Age _____**	**On time/Early/Late**
d. Speak real words?	**Age _____**	**On time/Early/Late**
e. Walk by self?	**Age _____**	**On time/Early/Late**
f. Feed self?	**Age _____**	**On time/Early/Late**
g. Use two-word sentences?	**Age _____**	**On time/Early/Late**
h. Speak so that strangers could understand?	**Age _____**	**On time/Early/Late**
i. Dress self (except for buttoning/tying)?	**Age _____**	**On time/Early/Late**

j. Pedal a tricycle? **Age _____ On time/Early/Late**
k. Ride a bicycle without training wheels? **Age _____ On time/Early/Late**
l. Tie own shoes? **Age _____ On time/Early/Late**
m. Become toilet trained? **Age _____ On time/Early/Late**

2. Do you have any of the following concerns about your child's motor development?

◯ None
◯ Muscle Tone
◯ Gross motor
◯ Fine motor
◯ Handwriting
◯ Other: _____

3. Do you have any of the following concerns about the child's language/speech development?

◯ None
◯ Unconnected thoughts
◯ Unintelligible
◯ Too few words in sentences
◯ Trouble finding the right word
◯ Seems easily confused
◯ Repeats words/phrases over and over
◯ Following directions
◯ Stuttering
◯ Speech clarity
◯ Other _____

4. Has your child ever lost language or regressed? **Yes/No**
a. If yes, how many words? _____
b. If yes, approximately how old was he/she? _____
c. If yes, please explain what may have caused it? _____
5. Has your child ever lost non-verbal communication (i.e. waving)? **Yes/No**
a. If yes, approximately how old was he/she? _____
6. Did your child enjoy dressing up? **Yes/No**
7. Did your child enjoy pretending (talk on phone, drive car, etc.)? **Yes/No**
8. Did your child learn pre-academic skills such as numbers, colors, shapes, etc. at the same time as other children his or her age? **Yes/No**
a. If no, please explain: _____
9. Have you ever been concerned or been told that your child's development (speech and language, coordination, growth, or social abilities) was behind his or her peers?

Yes/No

a. If yes, please explain:

_____
_____
_____

10. Tell us about your child's temperament:

◯ Easy going (easily comforted, sleeps well)
◯ Difficult (intense, irritable, sensitive)
◯ Slow to warm up
◯ Other _____

11. Has your child ever been seen by a speech therapist? Yes/No

E. Academic Development in School Aged Children

(If this section does not apply, cont. to section F)

1. Is your child receiving any special help at school? Yes/No
a. If yes, please explain: _____
_____
_____
_____
b. Is there an IEP or 504 plan in place? Yes/No
2. What is your impression of your child's learning potential?

◯ Slow ◯ Average ◯ Above Average ◯ Gifted

3. Do you feel child is performing up to his/her potential in school? Yes/No
a. If no, please explain: _____
_____
_____
_____
_____
_____
_____

4. Is homework a problem? Yes/No
a. If yes, check all that apply:

◯ Can't get started
◯ Forgets to bring home materials
◯ Doesn't understand the work
◯ Distracted by TV, radio, anything
◯ Battles or argues about doing homework
◯ Needs you by his or her side constantly
◯ No place to work
◯ Forgets assignments
◯ Doesn't anticipate deadlines
◯ Takes too long
◯ The most stressful time of day
◯ Other _____

5. Has your child ever been advanced a grade, retained, suspended, or expelled? Y/N

a. If yes, please explain:

_____
_____
_____

6. Please list all the schools your child has attended:

_____
_____
_____
_____
_____
_____

7. The following ratings reflect your child's level of specific skills and abilities:

	Good	Fair	Poor	Unsure
a. Catching and throwing a ball	◯	◯	◯	◯
b. Playing most sports	◯	◯	◯	◯
c. Drawing/Artwork	◯	◯	◯	◯
d. Building things	◯	◯	◯	◯
e. Understanding spoken directions	◯	◯	◯	◯
f. Understanding jokes and stories	◯	◯	◯	◯
g. Telling stories/describing things	◯	◯	◯	◯
h. Remembering telephone numbers	◯	◯	◯	◯
i. Telling time	◯	◯	◯	◯
j. Understanding what he/she reads	◯	◯	◯	◯
k. Rate of reading	◯	◯	◯	◯
l. Handwriting	◯	◯	◯	◯
m. Writing sentences or paragraphs	◯	◯	◯	◯
n. Spelling accuracy	◯	◯	◯	◯
o. Learning new math skills	◯	◯	◯	◯
p. Knowing what and how to study	◯	◯	◯	◯
q. Completing homework	◯	◯	◯	◯

F. Social Style & Self Esteem

1. Does your child get along well with others?
(Please check the best responses)

Makes friends easily	Yes/No	Has a best friend	Yes/No
Plays well with others	Yes/No	Shares easily	Yes/No
Follows rules	Yes/No	Enjoys team sports	Yes/No
Leads other children	Yes/No	Helps others	Yes/No
Prefers to be alone	Yes/No	A party animal!	Yes/No
Bullies others	Yes/No	Fights more than others	Yes/No
Easily Influenced	Yes/No	Prefers adults over peers	Yes/No

2. My child: (Please check the best responses)

Has "I can do it" attitude	Yes/No	Gives up easily	Yes/No
Stands up for self	Yes/No	Recovers from upsets	Yes/No
Recognizes strengths	Yes/No	Lacks confidence	Yes/No
Is adventuresome	Yes/No		

H. Your Family

1. Who does your child live with? (Please check the appropriate response)

◯ Both parents	◯ Mom and step-dad	◯ Dad and step-mom
◯ Single parent	◯ Shared arrangements	◯ Extended family
◯ Grandparent	◯ Other_____	

2. If divorced from biological parent:

a. What are the custody arrangements? _____

b. Is the non-custodial parent aware of this evaluation? Yes/No

c. Please list the names and ages of the other children living at home.

Name	Age	Biological sibling
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No

b. Any other comments? _____

3. Is there any family history of medical, developmental, learning, emotional, mental health, psychiatric, or legal difficulties? Yes/No