**Patient History & Registration Information**

*For Internal Use:*

|  |  |
| --- | --- |
| Patient name, first and last: |  |
| Gender: |  |
| Patient date of birth: |  |
| Parent(s) name(s), first and last: |  |
|  |  |
| Patient & parent address: |  |
| Marital Status: |  |
| Home phone(s):  |  |
| Parent(s) cell phone(s): |  |
| Parent(s) work phone(s): |  |
| Parent email address(es): |  |
| Is email a good way to correspond with you? |  |
| Do you give us permission to transmit information regarding your child’s speech therapy (updates, reports) to you via unencrypted email?  |  |
| Primary care physician/pediatrician clinic address/phone:  |
|  |  |
|  |
| Reason for referral & your primary concerns? |
|  |  |
|  |
| Please list names/ages of siblings or others living in the home: |
|  |  |
|  |

**Responsible Party/Insured’s Information**

|  |  |
| --- | --- |
| Name/Relationship of responsible party/Primary Subscriber: |  |
| Birthdate: |  |
| **Primary Insurance,** if applicable: |  |
| Policy Number: |  |
| Group Number: |  |
| Social Security Number: |  |
| Employer & Occupation: |  |
| Insurance claim phone number: |  |
|  | & address: |  |
| **Secondary Insurance,** if applicable: |  |
| Primary subscriber if different than above: |  |
| Primary subscriber date of birth, if different than above:  |  |
| Employer & Occupation if different than above: |  |
| Policy Number: |  |
| Group Number:  |  |
| Insurance claim phone number: |  |
|  | & address: |  |

**History Information: Medical/Birth History**

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| --- | --- |
| Were there any problems during pregnancy or difficulties at birth?  |  |
| If yes, please explain: |  |
|  |
| Has your child been hospitalized at any time? |  |
| If yes, please explain: |  |
|  |
| Has your child’s vision been tested? |  |
| When/Where/Results: |  |
|  |
| Has your child’s hearing been tested? |  |
| When/Where/Results: |  |
|  |
| Is there a history of allergies, colds, ear infections, illnesses or injuries? |  |
| If yes, please explain: |  |
|  |
| Are there any diagnosed mental, physical or emotional disabilities? |  |
| If yes, please explain: |  |
|  |
| Please list any medications your child is currently taking: |  |
|  |
| Is there a family history of speech, language or learning difficulties? |  |
| If yes, please explain: |  |

**Developmental/Learning History:**

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| --- |
| Has your child had prior evaluations (e.g., speech-language pathologist, occupational therapist, physical therapist, neurologist, psychologist or other professional)? |
| If yes: Where/When/Results? |  |
| What school does your child attend? |  |
| Grade level: |  |
| What feedback have you been given from your child’sschool or daycare regarding your child’s participation/skills? |
|  |  |
| Please describe any difficulties in: |
|  | Self Help skills (dressing, washing, brushing teeth, etc.): |  |
|  |  |  |
|  | Fine Motor skills: |  |
|  |
|  | Gross Motor skills: |  |
|  | At what age did your child walk unassisted? |  |
|  |
|  | Oral Habits (drooling, etc.): |  |
|  | Does your child use a pacifier? |  |
|  | If no, at what age did he/she stop? |  |
|  | Does your child suck his/her thumb? |  |
|  | If no, at what age did he/she stop? |  |
|  | Eating/Drinking (inadequate chewing, poor bite size control, choking, etc.):  |  |
|  |
| Please list a few of your child’s favorite snacks: |
|  |  |
| How does your child’s overall balance/coordination seem to you? |
|  |  |

|  |  |
| --- | --- |
| Is your child toilet trained, or in process?  |  |
|  |
| Is your child overly sensitive to touch, noise, clothing, etc.? |  |
| If yes, please explain: |  |
|  |
| **Speech-Language History:** |
| What is your child’s primary language? |  |
| Any other languages? |  |
|  |
| At what age did your child: |  |
|  | Begin to babble –  |  |
|  | Imitate sounds – |  |
|  | Say first word(s) –  |  |
|  | Put 2 words together – |  |
|  | Use longer sentences – |  |
| Was your child unusually quiet as a baby? |  |
| How does your child typically let you know what he/she wants?  |
|  |  |
|  |  |
| How does your child typically let you know that he/she understands what you are saying? |  |
|  |  |
| How much do you understand of what your child says? |  |
|  |  |
| How much do others understand? |  |

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| --- |
| How does your child react when others do not understand him/her? |
|  |  |
|  |
| Do you have concerns regarding stuttering? |  |
| If yes, please explain: |  |
|  |  |
| Do you have concerns regarding your child’s social or play skills?  |  |
| If yes, please explain: |  |
| What are some of your child’s favorite toys and/or activities? |
|  |  |
|  |
| What are your child’s strengths? |
|  |  |
| What are the most common behavioral challenges that you have with your child? |  |
|  |  |
| What strategies have you used and what seems to be most effective? |  |
|  |  |
| Is there anything else you would like us to know about your child, or your family? |  |