

# LITTLE CHATTERBOX SPEECH, LANGUAGE, AND HEARING SOLUTIONS, LLC



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## PATIENT INFORMATION

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Gender: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

MEDICAID: \_\_\_\_\_ INSURANCE INFO-  
: \_\_\_\_\_

Parents: \_\_\_\_\_

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Home Phone: \_\_\_\_\_ Work

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ REFERRED

BY: \_\_\_\_\_

Others living in the home:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Primary language spoken in the home: \_\_\_\_\_

CHIEF  
CONCERN: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

ADDITIONAL  
INFORMATION: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL/PHYSICAL INFORMATION**

Were there any problems during the pregnancy or was this pregnancy considered high risk?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please  
describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any problems during delivery? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please  
describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any problems with baby or mother in the hospital after birth? \_\_\_\_ Yes \_\_\_\_  
No

Were there any problems in the first few weeks at home? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please  
describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was your baby's hearing checked in the hospital? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, what were the results? \_\_\_\_\_  
\_\_\_\_\_

### GENERAL HEALTH

When was your child's last physical examination? \_\_\_\_\_

Are your child's immunizations up to date? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has your child had any of the following? (Please check)

- |                            |                        |                             |
|----------------------------|------------------------|-----------------------------|
| _____ adenoidectomy        | _____ encephalitis     | _____ scarlet fever         |
| _____ allergies            | _____ flu              | _____ seizures              |
| _____ anemia               | _____ head injury      | _____ sinusitis             |
| _____ asthma               | _____ heart problems   | _____ sleeping difficulties |
| _____ breathing difficulty | _____ high fevers      | _____ stomach problems      |
| _____ chicken pox          | _____ measles          | _____ thumb/finger sucking  |
| _____ colds                | _____ meningitis       | _____ tonsillectomy         |
| _____ ear infections       | _____ mumps            | _____ tonsillitis           |
| How often? _____           | _____ urinary problems | _____ vision problems       |
| _____ ear tubes            |                        |                             |

Has your child had any accidents or injuries? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Who is your child's pediatrician? Phone number?

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Does your child take any medications regularly? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please

list: \_\_\_\_\_

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Does your child's hearing seem to be normal? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, please

describe: \_\_\_\_\_

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Has your child's hearing been tested since birth? \_\_\_\_\_ Yes \_\_\_\_\_ No

Where? \_\_\_\_\_

When? \_\_\_\_\_

Results? \_\_\_\_\_

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Does your child wear hearing aids? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, for how long? \_\_\_\_\_

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Does your child:

Choke on food or liquid? \_\_\_\_\_ Yes \_\_\_\_\_ No

Currently puts toys/objects in his/her mouth? \_\_\_\_\_ Yes \_\_\_\_\_ No

Brush his/her teeth and/or allow brushing? \_\_\_\_\_ Yes \_\_\_\_\_ No

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Has your child had any other evaluation or therapy (PT, OT, ST)? \_\_\_\_\_ Yes \_\_\_\_\_ No

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Do you have any concerns about your child's motor development (small or large muscles) as compared to other children his/her age? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please

describe: \_\_\_\_\_

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## **SOCIAL**

Describe how your child gets along with:

Siblings: \_\_\_\_\_

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Other children: \_\_\_\_\_

Familiar adults: \_\_\_\_\_

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Strangers: \_\_\_\_\_

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## **LANGUAGE**

Describe how your child communicates:

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Does your child use:

\_\_\_\_\_ Body Language(gestures)                      \_\_\_\_\_ 2-4 word sentences  
\_\_\_\_\_ Sounds (vowels, grunts)                      \_\_\_\_\_ Sentences longer than 4 words  
\_\_\_\_\_ Single words (shoe, doggy, up)

\_\_\_\_\_ Repeat sounds, words, phrases over and over  
\_\_\_\_\_ Understand what you say  
\_\_\_\_\_ Retrieve/point to common objects upon request (ball, cup, shoe)  
\_\_\_\_\_ Follow simple directions ("Shut the door" or "Get your shoes")  
\_\_\_\_\_ Respond correctly to yes/no questions

\_\_\_\_\_ Responds to who, what, where questions

Do you understand what your child says? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If not, why?

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Do others understand what your child says? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If not, why?

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## **COGNITION**

How does your child play with toys?

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Do you have any concerns about the way your child plays with toys? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please describe:

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Does your child show awareness to what is going on around him/her? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child:

\_\_\_\_\_ Smile and vocalize in a mirror  
\_\_\_\_\_ Imitate sounds  
\_\_\_\_\_ Unwrap toys

\_\_\_\_\_ Name 3 objects  
\_\_\_\_\_ Point to 4 body parts  
\_\_\_\_\_ Give full name

## **FAMILY ASSESSMENT**

Briefly describe what your child's needs are.

What would you like to see your child accomplish this year?

What are some things your child likes doing?

What are some things your child does not like doing?

What are some things the family does together?

What are some things you are not able to do as a family anymore that you would like to be able to do again?

### **EDUCATIONAL BACKGROUND**

Has your child ever attended a childcare or nursery school? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, where:

Does your child's teacher have any concerns about your child? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please describe:

### **ADDITIONAL INFORMATION**

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