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:_____
_

Home Phone:_____ Work
Phone:_____

Address:_____
City:_____

State:_____ Zip:_____

EMAIL ADDRESS:_____ REFERRED
BY:_____

Others living in the home:
_____
_____
_____
___

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:_____
_____
_____

_____
____

Who is your child's pediatrician? Phone number?
_____
_____
__

Does your child take any medications regularly? _____ Yes _____ No
If yes, please
list:_____
_____
_____
__

Does your child's hearing seem to be normal? _____ Yes _____ No
If no, please
describe:_____
_____
__

Has your child's hearing been tested since birth? _____ Yes _____ No
Where?_____
When?_____
Results?
_____
_

Does your child wear hearing aids? _____ Yes _____ No
If yes, for how long?
_____

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

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

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:_____
_____
_____

_____
____

SOCIAL

Describe how your child gets along with:
Siblings:_____
_____
_

Other
children:_____

Familiar
adults:_____
_____
__

Strangers:_____
_____
__

LANGUAGE

Describe how your child communicates:
_____
_____
_____
___

Does your child use:

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

_____ 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?
_____
_____
_____
___

Do others understand what your child says? _____ Yes _____ No
If not,
why?_____
_____
_____
__

COGNITION

How does your child play with toys?
_____
_____
_____
_____
____

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

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