Speech, Occupational and
ABA Therapy Services

6801 Douglas Legum Dr, Suite A
Elkridge, MD 20855
1-877-776-8502

Date: _____

Person completing this form: _____Relationship: _____

CHILD IDENTIFICATION

NAME: _____ Birthdate: _____ Sex: M F Age: _____

Address: _____

Referred by _____

Mother's Name: _____ Age: _____

Address: _____

Phone: cell _____ home_____ work_____

Father's Name: _____Age: _____

Address: _____

Phone: cell _____ home_____ work_____

EMAIL ADDRESS: _____

Parents signature_____ Date _____

CHILD'S MEDICAL DIAGNOSIS: _____

Age Diagnosis_____

Siblings:

Name	Age	Sex	Grade	Speech/Hearing/Medical Problems

GENERAL DEVELOPMENT
Pregnancy and Birth History:

Which pregnancy was this child? ____ Length of pregnancy: _____

What illness, diseases, or accidents occurred during pregnancy? _____

Were there any problems at birth? Please describe: _____

Weight of child at birth: _____Any abnormalities? _____

Did the infant require oxygen? _____ Were there any problems during the first 2 weeks of the infant's life? (health, swallowing, sucking, feeding, etc.) _____

_____

MEDICAL HISTORY

Is your child currently under the care of a doctor? ____ Why? _____

Is he/she taking medication? _____ Type? _____Why? _____

Describe any illness, injuries, operations, or physical problems

_____

_____

DEVELOPMENTAL MILESTONES:

At what age did your child: sit up without support _____crawl_____

Roll over alone_____ walk_____ run _____use words _____

Speak in sentences _____ drink from a cup_____ use spoon, fork, knife_____

Dress self_____ first tooth: _____ completely toilet trained: _____

Hand Dominance: Right Handed_____ left handed_____

SPEECH/LANGUAGE:

Areas of Concern

Describe as completely as possible your concerns about the child's speech or language

problem:_____

_____

When did you first become concerned? _____

Have there been changes in the condition since you first noticed it? _____

What do you think caused this problem? _____

Does your child seem to be aware of the differences? _____

Has he/she has any therapy for speech or language? How has it helped? _____

_____

Are there any family members or relatives who have had speech or language problems?

Please specify: _____

Please circle all that apply:

Laughed less than normal	Large tongue
Cried less than normal	Difficulty chewing
Yelled or screeched for attention	Difficulty swallowing
Head banging and foot stamping	Gags or chokes easily
Temper tantrums	Difficulty moving mouth
Uncoordinated	Drooled a lot
Indifferent to sound	Food came out nose
Does not respond when spoken to	Mouth breather
Difficulty using tongue	Difficulty breathing
Tongue-tied	Talks through nose

SPEECH, LANGUAGE, AND HEARING HISTORY

How much did your child babble and coo during the first 6 months? _____

Did the development of your child's speech ever slow down or did he/she ever stop talking? _____

How does your child communicate? Circle those that apply:

Spoken words	Augmentative system:_____
Gestures	Physical guidance

If words were /are spoken please answer the following:

When did he/she speak their first words? _____

What were the child's first few words? _____

When did they begin to use two-word sentences? _____

Do they make sounds incorrectly? _____

How well are they understood?

By parent/caregivers? _____ By siblings?_____ By relatives and strangers? _____

Do they hesitate, "get stuck," repeat, or stutter on sounds or words? Please Describe:_____

How does his/her voice sound?

Circle: Normal Too High Too Low Hoarse Nasal Loud Soft

Are there any other languages spoken in the home? _____ Language: _____

How well does your child understand what is said to them? _____

_____

AUDIOLOGICAL HISTORY

Does your child have ear infections? _____ If so, how many? _____

Does your child hear adequately? If no, please specify. _____

BEHAVIOR

Chcck if these apply to your child:

Eating problems	Excitable
Sleeping problems	Laughs easily
Toilet training problems	Cried a lot
Difficulty concentrating	Sensitive
Stays with an activity	Emotional

Needed a lot of discipline	Happy
Difficult to manage	Gets along with other children
Underactive	Gets along with adults
overactive	Prefers to play alone

Does your child separate from parents without crying or fussing? _____

How do you discipline your child? _____

Does you child have a behavior modification plan? _____

Does he/she see a behavior specialist?_____

Name_____

EDUCATIONAL HISTORY

School now attending: _____ Grade: _____

Address: _____

Does your child have an Individualized Education Plan (IEP)? _____

Does you child attend a special education class? _____

Does your child have a dedicated educational assistant? _____

Subjects of interest/relative areas of strength: _____

Difficult subjects: _____

What is your impression of your child's learning abilities?

_____

_____

_____

OCCUPATIONAL THERAPY

Has an Occupational Therapist (OT) provided services to your child before? Yes__ No__

If so, when? _____ Why? _____

What were the OT's findings and suggestions?

_____
_____

Do you have a copy of the evaluation report? Yes__ No__

Parental Concerns _____
_____
_____
_____

What do you feel are your child's strengths? _____
_____
_____
_____

What are your concerns? _____
_____
_____
_____

What do you hope will be gained by having occupational therapy treatment if recommended?

_____
_____
_____

SELF CARE/DAILY ROUTINE:

Please describe your child's eating habits (include # of meals, # of snacks, food likes/dislikes

_____
_____
_____

If your child is experiencing feeding problems, please provide additional information: foods you child eats regularly: _____
_____

Foods your child used to eat but no longer eats _____
_____

Are there sensitivities to taste, explain _____
_____

Are there sensitivities to texture, explain _____

_____

Are there sensitivities to temperature, explain _____
_____

Are there concerns with your child's ability to bite, chew, move food around in the mouth, or swallowing, explain _____
_____
_____
_____

Please describe your child's sleep habits (include bedtime routine, # of hours, # of naps if any)
_____
_____
_____

Please describe how your child typically gets dressed. (Include how much assistance is needed, length of time, preference for certain fabrics/avoidance of textures) _____
_____

Can your child manage: snaps _____buttons _____zippers _____Buckles _____ Velcro enclosures _____ Tie shoes_____

Please describe bath time for your child (level of independence, like/dislike, preference for a bath or shower) _____
_____

Please describe your child's ability/tolerance of:

brushing teeth_____

brushing hair _____

washing hands/face_____

Is your child toilet trained? _____If so, when did this occur? _____

Please describe if there were/are any problems with toileting_____
_____

Please describe your child's ability to keep track of personal belongings_____
_____
_____

Please describe your child's ability to independently organize his/her bedroom, backpack, desk
_____

ATTENTION/SELF-REGULATION:

Does your child have a difficult time calming down to go to sleep or waking up in the morning?

If so, please explain_____
_____

Is your child irritable at predictable times of the day? If so, what events trigger this and when does it occur? _____
_____

Does your child seem happier or more cooperative at predictable times of the day? Please describe_____
_____

Does your child exhibit any impulsiveness, aggression, or immaturity more than other children his/her age? If so, please explain_____
_____

Describe your child's ability to attend to activities (responding to his/her name or a question in a timely manner, table top tasks -vs-gross motor activity-vs-homework)
_____
_____
_____

MOTOR SKILLS

Please describe your child's fine motor and visual motor skills (manipulation of small objects and toys/ dexterity, grasp on pencils/crayons, control/accuracy, quality of writing) **please do not leave this area blank**
_____
_____
_____

Please describe your child's gross motor skills (balance, coordination, jump/hop/ gallop/skip, endurance, strength) **please do not leave this area blank**
_____
_____
_____
_____

Can your child ride a bicycle (tricycle or two wheeler)?
_____
_____

Please describe your child's performance on jungle gym type equipment (preferences, tolerance for swings, climbing, level of independence)
_____
_____

Describe your child's play skills. Include his/her interests, favorite toys/games, pretend themes used in play, etc. _____

_____
_____

Does he/she use toys the same way each time play occurs or is his/her play constantly changing and evolving?

_____
_____

**PLEASE PROVIDE ANY ADDITIONAL INFORMATION you feel will help us in

understanding your child and his/her needs:

_____
_____
_____

FOR OFFICE USE ONLY

Date of Parent Interview: _____

Name of Staff Conducting Interview: _____

Additional observations, comments:

_____
_____
_____
_____
_____
_____

Recommended Follow-up:

_____
_____