Scottish Rite Childhood Language Center
CHILD INFORMATION FORM

DATE: _____

I. GENERAL INFORMATION

Name of Child: _____ Gender: male/female **Date of Birth: _____**

Address: _____

_____

Referred By: _____

Name of Parent/Guardian #1: _____ Relationship to Child: _____

Address (if different from child's): _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email Address: _____ **Please circle preferred phone number for us to contact you.**

Age: ____ Education: _____ Occupation: _____ Employer: _____

Name of Parent/Guardian #2: _____ Relationship to Child: _____

Address (if different from child's): _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email Address: _____ **Please circle preferred phone number for us to contact you.**

Age: ____ Education: _____ Occupation: _____ Employer: _____

Please indicate any pertinent legal or protective custody information: _____

_____

If parents work outside the home, who cares for the child? _____

Names of Siblings/Other Children: _____ Ages: _____

Who lives with child at home? _____

What languages are spoken at home? _____

Describe your child's problem as clearly and in as much detail as possible: _____

_____

_____

When did you notice the problem and what made you aware of it? _____

_____

_____

Please describe your goals or expectations for this evaluation/consultation/therapy: _____

_____

_____

IF YOUR CHILD WAS ADOPTED, please indicate child's age at the time of adoption _____.

II. PRENATAL HISTORY (Please check appropriate conditions)

Conditions of Concern During Pregnancy

_____ False labor _____ Illnesses (___ German measles; ____ viruses; ____ gestational diabetes; other: _____)

_____ Rh incompatibility _____ Other (i.e. accidents; medication taken; etc.): _____

Conditions of Concern During Birth

_____ Unusually long labor _____ Medication to induce labor _____ Premature birth (gestational age at birth:___weeks)

_____ Caesarean birth _____ Breech birth _____ Forceps required

_____ Other birth complications: _____

_____

Conditions of Concern Immediately Following Birth

_____ Anoxia (little or no oxygen) _____ Blood transfusion _____ Seizures

_____ Required Neonatal Intensive Care Unit _____ Sucking or swallowing problems _____ Feeding difficulties

_____ Jaundice – Treated medically? ____ No ____ Yes, with: ____ Sunlight ____ Bili-lights ____ Other (_____)

_____ Other difficulties (Please describe): _____

III. HISTORY OF ILLNESSES / DISORDERS (Check if applicable and specify at what age your child was diagnosed)

_____ Measles _____Lead exposure _____ Mumps _____ Seizures

_____ Scarlet fever _____ Meningitis _____ Encephalitis _____ Chicken pox

_____ Autism Spectrum Disorder (Asperger's / PDD) _____ Vision Disorder _____ Sleep Disorder

_____ Sensory Integration or Regulation Disorder _____ Fine or Gross Motor Skill Delay/Disorder

_____ Attention Deficit Hyperactivity Disorder (ADHD/ADD) _____ Speech or Language Delay/Disorder

List any other serious illnesses, disorders or injuries: _____

_____

Conditions Affecting the Ear (Note most recent episodes and frequency of occurrence)

_____ Tonsillitis _____Colds _____ Sinusitis _____ Allergies _____ Asthma _____ Strep throat

_____ Problem with earwax build-up _____ Ear canal infection (swimmer's ear) _____ Dizziness or imbalance

_____ Middle ear fluid or infection _____ Eardrum perforation (Right Ear / Left Ear) _____ Tinnitus (ear/head noises)

Surgery (Check if applicable and specify age or date)

_____ Tonsillectomy _____ Eardrum ventilation tubes _____ Repair of cleft palate

_____ Adenoidectomy _____ Clipping of frenulum _____ Other (Please describe) _____

_____

Medications

Please list all current medications (prescription/over-the-counter) and/or nutritional supplements your child is taking: _____

_____

Family History (Check if applicable and indicate their relationship to your child, i.e. father, elder sister, maternal brother)

_____Hearing loss _____ Speech-language disorders _____ Learning disabilities (i.e. dyslexia, ADHD)

_____ Seizures _____ Mental illness _____ Substance abuse

IV. DEVELOPMENTAL MILESTONES (Note which of the following skills were delayed, and if delayed, the age when the skill was acquired.)

_____ Babbled _____ Crawled _____ Ate with a spoon independently

_____ Used single words _____ Sat alone _____ Drank from a cup independently

_____ Combined 2 words _____ Walked alone _____ Toilet trained

_____Spoke in sentences

Check if Applicable

_____ Drools _____ Difficulty sucking, chewing, or swallowing _____ Difficulty drinking through a straw

_____ Difficulty grasping objects _____ Difficulty dressing independently (i.e. putting on clothing; buttoning; zipping; etc.)

_____ Difficulty walking _____ Seems uncoordinated or clumsy _____ Stumbles or falls frequently

_____ Difficulty with coloring, handwriting, or using scissors _____ Sensitive to clothing textures, tags, etc.

Please describe any concerns you have about your child's fine or gross motor skills and/or balance/coordination: _____

_____

Sleep (Check if applicable)

_____ Snores _____ Restless/active sleeper _____ Difficulty falling asleep _____ Difficulty staying asleep

_____ Does not wake up feeling rested and ready to go in the morning _____ Sleepy during the day

Please describe any concerns you have about your child's sleep habits: _____

_____

Has your child ever been tested for a sleep disorder? ____ No ____ Yes, please explain: _____

_____

V. AUDITORY BEHAVIOR (Check if applicable)

_____ Responds to name _____ Startles to loud sounds

_____ Seems to ignore sounds _____ Frightened by sounds (i.e. fire alarm; fireworks; other _____)

_____ Says "Huh?" or "What?" frequently _____ Has difficulty tuning out/ignoring background sounds

_____ Hypersensitive to sounds (cries, complains, avoids related activities)

_____ Responds to sounds consistently (telephone, doorbell, car horns, airplanes, sirens)

_____ Localizes sounds (turns head in the correct direction to locate the source of sounds or voices)

_____ Often requires statements, questions, or requests repeated before answering/responding

_____ Often mishears or misunderstands what is said _____ Has difficulty with phonics and speech sound discrimination

_____ Has difficulty remembering verbal directions _____ Is slow to follow or respond to things said to him/her

Has your child's hearing been tested? _____No _____Yes, When? _____ Where? _____

Describe results _____

VI. SOCIAL DEVELOPMENT (Check if your child exhibits these behaviors or has exhibited them in the past)

_____ Adaptable to new situations

_____ Enjoys being with people

_____ Plays well with other children

_____ Plays with toys appropriately

_____ Laughs and smiles appropriately

_____ Able to stay with an activity to completion

_____ Maintains eye contact with person speaking

_____ Easily managed in the home

_____ Eats well (all consistencies)

_____ Shows concern when separated from parent (separation anxiety)

_____ Understands/enjoys jokes and riddles

_____ Difficulty transitioning from one activity to another

_____ Tends to be a loner, preferring to be by himself/herself

_____ Prefers to play with children younger than himself/herself

_____ Overactive (unable to sit still without fidgeting)

_____ Overly excitable _____ Easily frustrated

_____ Easily distracted _____ Short or poor attention span

_____ Does not establish or maintain eye contact with person speaking

_____ Ignores punishment _____ Sensitive to being touched

_____ Often daydreams (stares off into space, in their own world)

_____ Uses echolalic speech (repeats what is heard verbatim, with no apparent communicative intent)

_____ Does not understand or use slang or figurative language

VII. SPEECH AND LANGUAGE BEHAVIOR (Please answer the following questions)

Articulation (How your child pronounces sounds)

_____ Yes _____ No Do you have trouble understanding your child's speech?

_____ Yes _____ No Do other people have trouble understanding your child's speech?

_____ Yes _____ No Does your child mispronounce sounds?

_____ Yes _____ No Is you child concerned about his/her speech?

Describe any concerns you have about your child's articulation. _____

_____

Language (How your child communicates)

How does your child let you know what he needs or wants? _____

How many words does your child use in a sentence? _____ Write a typical sentence: _____

_____

____Yes ____No Can your child name or point to body parts upon request?

____Yes ____No Can your child name or point to pictures upon request?

____Yes ____No Does your child follow simple commands? (Pick it up.)

____Yes ____No Does your child ask questions?

____Yes ____No Does your child know how to take turns in a conversation?

____Yes ____No Can your child maintain a topic in a conversation?

____Yes ____No Does your child hold appropriate phone conversations?

____Yes ____No Does your child tell stories or talk about experiences so that others can understand what happened?

____Yes ____No Does your child answer questions appropriately, ***without*** delays or requiring the question repeated?

____Yes ____No Does your child avoid answering questions, even though he/she may know the answer?

____Yes ____No Does your child follow 3-part commands, ***without*** delay or repetition? (Turn off the TV, wash your hands, then come to the table.)

____Yes ____No Does your child follow complex commands, ***without*** delay or repetition? (Before you go outside, finish your homework and put it in your backpack.)

____Yes ____No Does your child often use vague, nonspecific or incomplete references, like "stuff", "thing", "it"?

____Yes ____No Does your child have difficulty with retrieval of some common words/names when communicating?

____Yes ____No Does your child have difficulty expressing his/her thoughts completely?

____Yes ____No Does your child misuse/misunderstand/mispronounce words with similar sounds or multiple syllables?

____Yes ____No Does your child often use fillers when talking, like, "um", "uh", "you know"?

____Yes ____No Does your child often quietly repeat a question or key words to himself/herself prior to answering.

____Yes ____No Does your child talk all around a subject, add a lot of incidental information, but never get to the point?

____Yes ____No Does your child forget what he/she is talking about, or have difficulty returning to a topic if interrupted?

____Yes ____No Does your child have difficulty spontaneously correcting himself/herself after realizing that he/she misspoke or said something wrong?

VIII. FLUENCY

____Yes ____No Has anyone in your family's history had a problem with stuttering? If yes, who? _____
_____

____Yes ____No Does your child repeat sounds or words when speaking? (Ca-ca-ca-can I have the ball?)

____Yes ____No Does your child prolong sounds when speaking? (sssssnake)

____Yes ____No Does your child speak too quickly?

____Yes ____No Does your child avoid certain situations because of his/her speech?

IX. EDUCATIONAL HISTORY

Name of school: _____ Present level in school: ___ grade

____ Yes ____ No Does your child have difficulty academically in school? If yes, in which subjects? _____
_____

____ Yes ____ No Does your child have difficulty socially in school?

____ Yes ____ No Does your child have difficulty completing homework assignments in a timely manner?

____ Yes ____ No Does your child have difficulty following verbal directions in the classroom?

____ Yes ____ No Does your child read at grade level? If no, at what grade level is he/she reading? _____

____ Yes ____ No Does your child have difficulty with writing assignments or putting thoughts into words? If yes, please explain _____
_____

____ Yes ____ No Has your child repeated a grade? If yes, which one(s)? _____

(Please remember to sign Page 6 of 6.)

____ Yes ____ No Has your child ever received speech and language evaluation or therapy services?

If yes, at what age and for how long: _____

Please name service provider(s): _____

____ Yes ____ No Has your child ever received any other evaluation or therapy services? If yes, please indicate at what age, for how long, and the name of the service provider.

Occupational Therapy/Evaluation: _____

Physical Therapy/Evaluation: _____

Vision Therapy/Evaluation: _____

Psychological Evaluation/Counseling: _____

Academic/Educational Evaluation/Tutoring: _____

Other (Please describe): _____

____ Yes ____ No Currently, does your child receive any special services? If yes, please indicate whether your child receives the service(s) through his/her school (S), or privately - outside of school (O).

_____ Occupational therapy _____ Physical therapy _____Vision therapy _____ Tutoring

_____ Speech and language therapy _____ Special education classroom _____ Resource room

_____ Reading services Other (Please describe): _____

Please indicate your child's favorite pastimes (i.e. activities; sports; hobbies; talents; interests; etc.): _____

_____

_____

_____

Please indicate any problem behaviors, unusual/intense fears, extreme dislikes, or sensitivities your child may have: _____

_____

_____

_____

Completed by: _____

Relationship to child: _____

Thank you for taking the time to complete this form. The information you provide is extremely helpful to us as we evaluate and/or provide therapy for your child.

Scottish Rite Childhood Language Center