Lynn C. Koss, M.S. CCC - SLP

Thank you for taking the time to complete this form. Not every question will be applicable to your child. There is room on the last sheet to add additional information. Please do the best you can. This is a team effort and you are a vital part of the team!

Child's Full Name_____

Date of Birth: _____
Month Day Year

Address: _____
Street City State Zip Code

Telephone: (Home) _____(Mobile)_____(Work)_____

E-mail:_____

Name of Person Completing Form_____ Relationship to Child_____

Referral Source/ How did you find us? _____

What are the problems that your child is experiencing that led you to seek this evaluation?

_____

_____

_____

_____

_____

_____

Family

Parent's Name: _____ Age: _____

Occupation: _____ Educational Level: _____

Parent's Name: _____ Age: _____

Occupation: _____Educational Level: _____

Child's Siblings: Name: _____ Age: _____ Sex: _____

Name: _____ Age: _____Sex: _____

Name: _____ Age: _____Sex:_____

Does your child have different biological parent(s). If yes, please explain: _____

_____

Is your child adopted? _____ If yes, at what age? _____ If it was a foreign adoption, from what country? _____

Are any of your child's siblings experiencing any medical problems (please explain):_____

_____

Are any languages other than English spoken at home? If yes, which one(s)? _____

Please list family members and others who are living in the home _____

Family Medical History (questions about child's medical history will come later in the form). For the following, please state the relationship to the child (biological siblings, mother, father, aunts, uncles, grandparents, cousins). If there are multiple people with the problem, please indicate them all.

Relationship to Child

Speech-language disorders (please specify if you know) _____

_____

Genetic disorder (e.g., Down Syndrome, VCFS, please specify) _____

_____

Attention Deficit Hyperactivity Disorder (ADHD) _____

_____

Learning Disabilities, Dyslexia, or other educational difficulties: _____

_____

Malformation of the head, neck or ears, including cleft lip or palate: _____

_____

Mental Illness (Please specify if you know)

_____

_____

Delayed Motor Development _____

_____

Sensory Disorders: _____

_____

Autism Spectrum Disorders including PDD-NOS and Asperger's Syndrome: _____

_____

Tourette's Syndrome or Tics: _____

_____

Childhood Hearing impairment (including Auditory Processing Disorder):_____

_____

Seizure disorder: _____

_____

Other:_____

_____

_____

Prenatal and Birth History (In this section, please write *yes*, *no*, or, if the birth mother's condition is unknown to you, write *unknown*)

Did the mother experience previous miscarriages? _____ If yes, how many _____ Were there stillbirths? ____

_____ Did mother have IVF to achieve this pregnancy? If yes, Please describe: _____

_____

Did the mother experience:

Excessive vomiting: _____ Pre-eclampsia: _____

Bleeding: _____ Rh Incompatibility: _____

Weight loss: _____ Diabetes: _____

Premature rupture of membranes:_____ Need for best rest: _____

Smoking: _____ Recreational Drug use: _____

Accidents or falls: _____ Hospitalizations: _____

Illnesses: _____ Medical treatments: _____

Exposure to the Zika virus: _____ Exposure to Ebola: _____

If you answered yes to any of the above, please provide additional details: _____

_____

_____

_____

Please list medications taken by the mother during pregnancy, including Selective Serotonin Reuptake Inhibitors (SSRI)._____

Number of ultrasounds _____ Any high–resolution? _____Did the mother have amniocentesis? _____ If yes, what were the results? _____Was Chorionic Villi Sampling (CVS) performed? _____ If yes, what were the results? _____

Did the mother receive genetic counseling? _____

In general, how would you describe the mother's health during the pregnancy? _____

_____

Did the baby receive any in-utero treatments? _____

Labor and Delivery

Was labor induced? _____ If yes, was it before term, at term or after term? _____ What was the reason? _____

Type of anesthesia, if administered: _____

Estimate of Total Length of Labor_____ Length of "Hard" Labor: _____

Were there difficulties during labor? If yes, please explain: _____

_____

Please circle type of delivery: head first feet first breech Caesarian

Were there difficulties during birth? If yes, please explain: _____

_____

If you know the baby's Apgar scores, please include: 1st score _____ 2nd score _____ Birth weight: _____

Did the baby experience any difficulties breathing or other problems after delivery? If yes, please describe.

_____

Was the baby put in the Neonatal Intensive Care Unit? (NICU) If yes, please explain including length of stay):_____

_____

Did the baby receive other special treatment, such as lights for jaundice? If yes, please specify: _____

_____

Was the baby diagnosed with the following? Fetal alcohol syndrome _____ Drug Addiction _____

Length of hospital stay for the mother: _____ Length of hospital stay for baby: _____

How was the infant fed? (Circle one) Breast Bottle Other

If breast fed, did the baby have difficulties latching? _____If yes, how was it resolved? _____

If breast fed, until what age? _____ Did the baby transition to: bottle sippy cup cup

If bottle fed from birth, please describe any feeding difficulties? _____

_____ Allergies to formula? _____

When was the baby weaned from a bottle (even if initially breast fed and switched? _____

Baby's First Year

Did the baby experience the following during the first year or have other difficulties?

Colic: _____ Excessive trouble sleeping: _____ Regurgitation: _____ Difficulty adding solid foods: _____ Difficulty gaining weight: _____ Other: _____

If you answered yes, please describe or add additional information: _____

_____

Motor and Sensory Development

At what age did your child (If not yet accomplished, mark "not yet.") Sit unsupported? _____ Crawl? _____
Stand alone? _____ Walk alone? _____ Use a spoon? _____ Dress self? _____ Potty train?_____
Does your child display a hand preference? _____ If yes, which one _____

Is the same hand used for holding a fork or spoon as for holding a pencil or throwing a ball? _____

Would you consider your child awkward or clumsy? _____

Does your child play any sports or engage in other physical activities? _____If so, which ones?_____

_____

Does your child dislike wearing certain clothing, maybe because it is rough or scratchy? _____ If yes, please explain.

_____

Does your child seek out certain sensory experiences, maybe swinging or rocking, or liking to sleep with many blankets even when it's not very cold? If yes, please explain. _____

Medical

Please provide the age(s) or the dates when your child was diagnosed with or experienced any of the following:

Allergies (list): _____	Asthma _____	Concussion _____
_____	Croup _____	Dizziness _____
_____	Encephalitis _____	Diphtheria _____
Bad Colds _____	Ear Infections_____	High fevers _____
_____	_____	_____
Strep _____	PANDAS_____	OCD _____
Pneumonia _____	Tonsillitis _____	Delirium _____
Seizures _____	Lyme Disease: _____	Headaches _____
Autism Spectrum _____	ADHD _____	Genetic Disorder _____
Sensory Disorder _____	Asperger's Syndrome _____	Sleep Apnea _____

Tourette's Syndrome _____ Tics _____ Pervasive Devel. Disorder _____

Tongue Tie _____ Vocal Fold Disorder _____ Other _____

Please explain treatment and current status of pertinent items above: _____

_____

Please list the frequency and dosages of medications you child is currently taking: _____

_____

Please list vitamins and supplements your child takes: _____

If your child has had surgeries, please list the type or reason (e.g., adenoidectomy) and the dates: _____

_____

If your child has had other hospitalizations, please list the reasons and the dates: _____

_____

List any accidents or injuries (including head injuries) that required medical attention, not listed above, and please include your child's age at the time: _____

_____

How does your child sleep? (Falling asleep and staying asleep) _____

Does he/she snore? _____ About how many hours of sleep does your child get each night? _____

Oral-motor and Eating

If your child used a pacifier, at what age did he or she start? _____ Until what age? _____

Has your child ever sucked his or her thumb, other fingers or hand? _____ If yes, until what age?_____

Did your child have eating difficulties that persisted past the first year of life? Check each item that applies

Difficulty chewing or swallowing? _____ If yes, is meat most difficult? _____

Reflux/vomiting _____ Choking or gagging? _____

Does your child want to eat nonfood items, such as toothpaste? _____

Is your child a picky eater? _____ Does your child frequently chew gum? _____

Did/does your child drool more than children his/her age? _____

Does your child typically keep his/her mouth open (mouth breather?) at rest? _____ while asleep?_____

Dental

Does your child's dentist or orthodontist express concerns? _____

Did or does your child have a dental malocclusion? If so, do you know the type? _____

Has your child had dental appliances such as "tongue tamers," palatal expanders, or braces?_____

Was your child diagnosed with "tongue thrust"? _____ Does your child grind her/his teeth? _____

Speech and Language

Please indicate the age at which your child first demonstrated the following:

Behavior	Age
Babbling (ba-ba, da-da etc)	_____
Single words	_____
Combining words (e.g., go bye-bye)	_____
Sentences	_____

Did your child's language development seem to stop for a period of time? _____ If yes, when? _____

When your child was between 3 and 5 years old, did he or she have trouble following directions or understanding statements? _____

Did you or others having difficulty understanding your child after he/she turned 3 years old? _____

If your child is currently having difficulty producing sounds, which ones are they? _____

Does your child have a hard time thinking of the right word? _____ Does your child get frustrated trying to explain something? _____

Compared to other children, do you think your child (circle one): talks less talks more about the same

Does your child like being read to? (Circle one) Yes No Yes, but only if there are pictures

Does your child currently have trouble carrying out multi-step directions _____

Do you have concerns about the quality of your child's voice (for example, hoarseness, pitch, loudness or other concerns) _____

Does your child frequently repeat whole words? _____ Pats of words? _____ Does your child seem to get "stuck" on a word?_____

Hearing

Has your child ever has his/her hearing tested? _____ If yes, where or by whom? _____
What was the date or how old was your child? _____ What were the results/ recommendations? _____

_____

Does your child ever complain about loud noises or get upset in noisy places like crowded restaurants or concerts?

Do you sometimes suspect your child may have a hearing problem of some kind? _____ If yes, what behaviors lead you to suspect this? _____

_____

Does your child sometimes ask you to repeat what you have said, or say "Huh?" or "What?" often or misunderstand _what you have told them? _____ If yes, please explain or give an example _____

_____

Does your child follow conversations in a group as well as in a one-to-one situation? _____

_____

Vision

If your child wears glasses, please circle the appropriate description: for reading for distance for both other (please explain)_____
When was your child's last eye exam? _____Where? _____

Has your child been diagnosed with eye tracking problems? _____

Does your child complain of tired eyes?_____ (If yes, please give example)_____

Play and Other Activities

For children 4 years old or under, please respond to the following: Which of the following describes the type of play your child likes to engage in most often? (check all that apply) Putting toys in mouth ____ Banging toys together ___ Throwing toys ____ Shaking toys _____ Pushing/pulling toys _____ Putting toys in rows _____ Appropriate use of objects e.g., uses a play cooking set to pretend to cook _____

Acting out familiar routines _____ Playing on I-Pad or other electronic game devices _____ Watching movies/shows ____ Looking at print books or e-books _____ Other (please describe)_____

_____

For children 5 years old or older, please respond to the following:
Indicate which of the following describes the type of play your child likes to engage in most often? Acting out familiar routines _____ Pretending an object is something else _____ Playing make-believe _____ Games with rules _____ Rough and tumble play _____ Playing I-Pad or other electronic games _____ Watching movies/shows ____ Looking at print books or e-books _____ Other (please describe)

_____

If your child attends after-school activities, please list them here, along with the number of days per week.

_____

What are your child's favorite toys, games, activities, DVDs or hobbies? _____

_____

Social, Emotional and Behavioral Development

Please check the behaviors that describe your child:

overly active ___	often afraid and anxious ___	rather play alone ___
overly quiet ___	friendly, outgoing ___	likes routines ____
excessive tantrums ___	plays well with same age-children ____	defiant ___
destructive ___	prefers older children ____	often angry ___
very shy ___	prefers younger children ____	passive ___
perfectionistic ___	prefers to play with parent ____	easily distracted _____
trouble separating __	often daydreams ____	impulsive _____
very organized ___	very disorganized ____	unfocused _____

Please comment on the above perhaps giving examples: _____

_____

Memory

Does your child have difficulty recalling directions? _____ Can you think of an example? _____

_____

De you think it is easier for your child to remember something she or he has heard or something that she/he saw?

_____

Does your child have difficulty remembering spelling words for tests? _____ Math facts?_____

Please elaborate, if you wish _____

Education

What grade is your child in? _____ Has your child ever repeated a grade? _____If yes, which one? _____

What is the name and address of your child's school? _____

Teacher's name(s)? _____

Does your child have an Individualized Education Plan (IEP)? _____ If yes, what is the classification? (for example "Other health impared")_____

Does your child have a 504 plan? _____ If yes, what are the accommodations? _____

Does your child receive Academic Intervention Services (AIS)? _____ In what areas?_____

Does your child stay after school for additional help? (If yes, how often and in what subjects?)_____

_____

What is your child's favorite subject(s) in school? _____ Least favorite? _____

Does your child have a modified curriculum? (if yes, explain)_____

Is your child able to take notes? (If applicable) _____

Has your child been evaluated by any of the following **school** professionals?

	Name	Date or Grade	School
Educational psychologist			
Speech-language pathologist			
Physical therapist			
Occupational therapist			
Educational audiologist			
Other			

Does your child receive any of the following **school** services?

Service	Date/Grade Began	Date Ended (or on-going)	Times per week
Self-contained class			
Resource Room			
In-class support			
Speech Therapy (individ)			
(group)			
Occupational Therapy			
Physical Therapy			
Other			

If your child received evaluations or treatment **outside of school**, please provide the name or location and the dates (if treatment was over a period of time provide the number of times per week).

	Name	Date(s)
Neurologist		
Developmental Pediatrician		
Psychologist		
Speech-Language Pathologist		
Occupational Therapist		
Physical Therapist		

Psychiatrist _____

Psychologist _____

Social Worker_____

Other _____

Please add information or your thoughts or observations that you feel may be helpful _____

_____

_____

_____

_____

_____