



Mother's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_

Address \_\_\_\_\_  
Street city/state zip code

Mother's Employer &  
Address \_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_  
Home Work Cell

Parents Marital Status \_\_\_\_\_

Siblings &  
Birthdates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other persons living in the home \_\_\_\_\_

Second language in home \_\_\_\_\_

Nature of problem \_\_\_\_\_

Date of  
Onset \_\_\_\_\_

Has your child been evaluated previously for this problem? \_\_\_\_\_

If yes, where? \_\_\_\_\_

Date of evaluation \_\_\_\_\_

**FAMILY HISTORY**

Have any of the following conditions affected members of your immediate family?

Cleft Lip/Palate _____	Neurologic Disease _____
Deafness _____	Stuttering _____
Delayed Speech _____	Other _____

Is your child adopted? \_\_\_\_\_

If so, at what age? \_\_\_\_\_  
Is he/she aware of the adoption? \_\_\_\_\_

**PREGNANCY AND BIRTH HISTORY**

Did you have major health problems, injuries or surgeries during your pregnancy? \_\_\_\_\_

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check any of the following that were applicable to you during your pregnancy:

German Measles \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_  
RH/blood Incompatibility \_\_\_\_\_  
Virus Infections \_\_\_\_\_  
Other \_\_\_\_\_

How long was your labor? \_\_\_\_\_

Describe any labor complications \_\_\_\_\_  
\_\_\_\_\_

How long was your pregnancy? \_\_\_\_\_

What was your baby's birth weight? \_\_\_\_\_

Were there any complications at the time of the delivery? \_\_\_\_\_

If so, what complications? \_\_\_\_\_

**EARLY DEVELOPMENTAL HISTORY**

After birth, did the baby have any of the following conditions?

Convulsions \_\_\_\_\_  
Feeding problems \_\_\_\_\_  
Heart monitoring required \_\_\_\_\_  
Serious infections \_\_\_\_\_  
Severe jaundice \_\_\_\_\_

At what age did your child sit alone? \_\_\_\_\_

At what age did your child walk alone? \_\_\_\_\_

At what age did your child feed self? \_\_\_\_\_

At what age did your child say his/her first word? \_\_\_\_\_

At what age did your child talk in sentences? \_\_\_\_\_

Does your child play with other children? \_\_\_\_\_

Does your child have severe or prolonged temper tantrums? \_\_\_\_\_

Does your child appear to have poor coordination? \_\_\_\_\_

Has your child suffered from chronic ear infections? \_\_\_\_\_

If yes, how many ear infections have they had? \_\_\_\_\_

Does your child have tubes in their ears? \_\_\_\_\_

Has your child ever had a psychological or neurological exam? \_\_\_\_\_

If so, where? \_\_\_\_\_ When? \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_

If so, what was the reason? \_\_\_\_\_

Length of stay \_\_\_\_\_ Date \_\_\_\_\_

Is your child currently receiving any other forms of therapy (ie, occupational or physical therapy) or has he/she received other forms of therapy in the past?  
\_\_\_\_\_

If so, what type of therapy? \_\_\_\_\_

Date therapy began \_\_\_\_\_ Frequency of therapy \_\_\_\_\_

Is your child currently taking medications? \_\_\_\_\_

If so, name of medication \_\_\_\_\_

Reason for medication \_\_\_\_\_

**EDUCATIONAL INFORMATION**

Name of school child is presently attending

\_\_\_\_\_

Describe general progress and behavior in school

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your child receiving any special services at school (ie, speech therapy, occupational therapy, tutoring, reading support, etc.)?

\_\_\_\_\_

\_\_\_\_\_

Does your child appear to exhibit learning problems? If so, what academic areas?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PARENT COMMENTS**

Please describe any additional concerns/information you may have about your child's speech and language at this time.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SERVICE AGREEMENT**

Speech and language services are provided for the patient with the understanding that payment for such services is the responsibility of the patient, parent or guardian. Payment is required at the **beginning** of the session unless other arrangements have been made.

A **24-hour** cancellation is required; otherwise failed appointments will be billed to the responsible party at our regular rate. Two failed appointments may result in cancellation of speech therapy services.

I have read and agree to comply with the above policies.

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

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

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

Date: \_\_\_\_\_

**CONSENT FOR RELEASE OF INFORMATION**

Patient \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby give my consent for release of information concerning the evaluation and treatment of the above patient to the following people:

1. Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City/state Zip code

Telephone \_\_\_\_\_

2. Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City/state Zip code

Telephone \_\_\_\_\_

3. Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City/state Zip code

Telephone \_\_\_\_\_

I understand that Foundations Speech and Language Services LLC preserves the confidentiality of client information. I further understand this release is valid for the period of time in which the patient is in active treatment with Foundations Speech and Language Services LLC or until revoked by the responsible party. A photocopy of this consent may be used as the original.

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Signature of Responsible Party

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Date