



**Client Name:**

**Date of Birth:**

**CURRENT CONCERNS**

**What are your specific questions/concerns about your child's speech, language, and/or learning?**

**What do you hope to learn from this evaluation?**

**CURRENT COMMUNICATION STATUS**

**How does your child communicate? (please check all that apply)**

- crying**
- pointing or hand gestures - not pointing /grabbing gesture**
- grabbing objects**
- takes you to place or object -**
- facial expressions**
- "own language"**
- words:**
- sentences**

**Please check any areas of difficulty that you observe:**

**Language**

**Understanding**

- Understanding vocabulary:**
- Following directions**
- Remembering what you tell him/her**
- Listening & understanding quickly & easily (e.g., Says "what?" or "huh?", misunderstands frequently)**

### **Speaking**

- Combining words (Using 2 or more words to form phrases or sentences)**
- Using vocabulary / retrieving words**
- Using grammar**

### **Social Communication**

- Following rules of conversation (e.g., Initiating/ending conversation, taking turns, staying on topic)**
- Making eye contact**
- Making friends/Getting along with others**
- keeping up with other kids in conversation**

### **Speech**

- Saying words clearly, pronouncing sounds**
- Saying words smoothly**
- Hoarse or nasal voice**

### **Hearing**

- Hearing what people say in conversation**
- Turning TV up louder than average**

### **Reading/Writing**

- Recognizing or “sounding out” words when reading**
- Reading comprehension**
- Spelling**
- Handwriting**
- Writing sentences, stories, reports**

### **Attention/Organization**

- Loses interest in activities quickly (e.g., sitting, reading, playing)**
- Organizing homework and schoolwork in book bag, locker, binders**
- Remembering to bring home assignments**
- Remembering to hand in assignments**
- Initiating and completing home assignments independently**
- Completing home assignments within expected time frames**

**BIRTH HISTORY**

Full Term	YES/NO	If no, length of pregnancy:
Complications	YES/NO	If yes, please explain:
Adopted	YES/NO	If yes, age at adoption:

**MEDICAL HISTORY**

Please list any diagnoses, serious illnesses, injuries, or hospitalizations and dates: \_\_\_\_\_

Does your child have a history of ear infections?

If yes, when was the most recent infection: \_\_\_\_\_

Has your child had their hearing examined?

If yes, when? \_\_\_\_\_ If yes, what were the results? \_\_\_\_\_

Did your child pass a newborn hearing screening? \_\_\_\_\_

Has your child ever received pressure equalizing tubes in their ears?

If yes, when? \_\_\_\_\_

Does your child have vision impairments?

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

Does your child take any medications?

If yes, please list: \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Did/Does your child have any difficulty with feeding or swallowing (e.g., drooling, chewing, gagging, picky eater)?

Did/Does your child have any difficulty with motor development (e.g., sitting, walking, toilet training, using cup/utensils, drawing, writing, overall coordination, running)?

At what age did your child do the following?				
<b>Babble</b> (Use consonant + vowel repeated over and over, e.g., ga-ga, pa-pa-pa)	<b>Jargon</b> (sounds like a sentence but does not contain real words)	<b>Say first words</b> Examples: _____ _____	<b>Combine 2 or 3 words</b> Examples: _____ _____	<b>Use Sentences</b>
6-9 months	6-12 months	9-12 months	19-24 months	2-2 ½ yrs.
10-12 months	12-18 months	12-15 months	2-2 ½ yrs.	2 ½ -3 yrs.
13-15 months	18+ months	16-18 months	2 ½ -3 yrs.	3-3 ½ yrs.
		19-24 months	3-3 ½ yrs.	3 ½-4 yrs.
		other:	other:	3 ½-4 yrs.

**FAMILY HISTORY**

Is there any family history of speech, language, learning or communication difficulties?

If yes, please explain:

Who does your child spend time with?						
Please include parents, grandparents, siblings, daycare providers, etc.						
Name	Relationship to Child	age	Education	Occupation	Language(s) Spoken with child	Does this person live in the home?
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO
						YES NO

**LANGUAGES SPOKEN**

What languages are spoken at home? (please list all that apply)

If your child hears or speaks more than one language, please complete the following questions. If not, proceed to the SERVICES RECEIVED section.

Language	Child's understanding is:	Child's ability to speak is:	Estimate percentage of time child uses this language
	Good Fair Poor	Good Fair Poor	%
	Good Fair Poor	Good Fair Poor	%
	Good Fair Poor	Good Fair Poor	%

What is your child's preferred language? English

**Where** was your child first exposed to English? ( Home ) ( Daycare ) ( School ) other: Home\_\_\_\_\_

**When** was your child first exposed to English?

Are problems noticed in all languages? NO

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

**SERVICES RECEIVED**

Has your child had any previous evaluations (in or outside of school)?

Neuropsychological	(Yes) (No) Date:	Occupational Therapy	(Yes) (No) Date:
Speech-Language	(Yes) (No)	Physical Therapy	(Yes) (No) Date:
Educational Testing	(Yes) (No)	Other:	(Yes) (No) Date:

What services does/did your child receive? Please check all that apply: None

Current Past

Speech Language Therapy

Physical Therapy

Occupational Therapy

Developmental Specialist

Playgroup

Library playgroup

Reading/Writing Support

What services does/did your child receive? Please check all that apply:

Current Past

Math Support

Academic Support

ELL Services (English Language Learning)

Counseling

Intensive Services

(e.g., ABA, Building Blocks/ESDM, DIR/Floor Time)

**Behavioral Support  
Early Intervention (EI) services**

If currently enrolled, what is the name of your Early Intervention and Service Coordinator: \_\_\_\_\_

\_\_\_\_\_

Is your child enrolled in a daycare or school? ( DAYCARE) ( SCHOOL) ( NONE)

School	Type of Program	Days/Hours per week?	Language(s) spoken	Does your child receive specialized services at school?
<b>Name:</b>	( Regular)			Individualized Education Program (IEP) <i>If yes, dates:</i>  504 Plan <i>If yes, dates:</i>  None at this time
<b>Town:</b>	( Integrated Classroom)			
<b>Grade:</b>	( Language-Based ) ( Substantially Separate) ( Private School)			

Please list any other information that you feel may be helpful: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_