EDUCATION AND THERAPY ASSOCIATES, INC.
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Patient Billing Information

Child's name: ____________________________________Today's date: ________________________________

Date of birth: ______________Age: _____Grade level: __________School: ______________________________

Home Address: ____

Home Phone #: ____

Form Completed by: □ Mother □ Father □ Guardian □ Caregiver □ Other: __________________

Family Information:

Parent/Guardian: ____ Age: _____________

Occupation: _________________________________ Employer: ______________________________________

Address: ____

Alt. Phone #:(w) ___________________ (c)____________________ E-mail address: ______________________

Parent/Guardian: ____ Age: _____________

Occupation: _________________________________ Employer: ______________________________________

Address: ____ Alt. Phone #:(w) ________________ (c)__________

Mailing address (if different): ____

Billing address: ____

Referred by: ____

Statement of Problem:

Describe the concerns you have about the child's communication skills at this time: ________________________

____

____

What do you think may have caused the difficulties this child is experiencing? ____________________________

____

____

When was the problem first noticed? Please specify date and person(s): __________________________________

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____

Are there any skills the child had learned previously, but can no longer use? ______________________________

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____

Has the child's hearing been tested? □Yes □ No If yes, please bring a copy of the hearing test results to your appt.

If yes, where was the test completed? ___________________________________ Date Completed? ______________

Results of the hearing test: □ Hearing within normal limits □ Hearing loss □ Further testing required

Name(s) of Others Living With Child	Relationship to Child	Age	Sex

Have any family members had any speech, language, hearing problems, or learning difficulties?
□ No □ Yes If Yes, who? ____________________________________ Please describe: _______________________

____

What languages are spoken in the home? ____

What is the primary language used with this child? ____

Was this child adopted? □ No □ Yes If Yes, at what age? _________________ From Where? _______________

Child's Medical History:

Name of Child's Physician: __________________________________ Medical Office: _________________________

Describe the mother's health during pregnancy: □ Good □ Fair □ Poor

Were there any unusual conditions or problems during the pregnancy or birth? □ No □ Yes If yes, please describe:

____

____

Were there any drugs or alcohol consumed during the pregnancy? □ No □ Yes If yes, what and how often?

____

Was the pregnancy full term? □Yes □No If no, how early or late? ____

General condition: _____________________________ Birth weight: _______________________________________

Does your child have any medically diagnosed illness or conditions? □Yes □ No If yes, please explain:

____

____

Is your child taking any medications? □Yes □No If yes, please list: ____

____

Has your child experienced any of the following?
□ Frequent Colds □ Seizures □ Snoring □ Mouth Breathing □ Sleeping Problems
□ Frequent Ear Infections □ Other: ____

Has your child had any surgeries, accidents or hospitalizations? □ No □ Yes If yes, please explain: _____________

____

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)? □ No □ Yes If yes, please explain: ____

Is there anything else we should know about your child's medical history? □ Yes □ No If yes, please explain:

____

Has your child had any of the following evaluations or assessments? Please indicate:

□ Hearing □Speech and Language □Psychological □Physical Therapy

□ Neurological □Occupational Therapy □Developmental □Vision

What were the results? ____

____

____

____

____

Has your child received any of the following services? □ Speech/Language □ OT □ PT □ Nursing

Please be sure to bring copies of any evaluations, treatment plans, or IEPs, etc

Developmental History:

Please provide the approximate age at which the child acquired the following skills. If you can't remember tl check the box that best describes when he/she acquired the skill as compared to his/her peers.

Activity	Age	Earlier than Peers	Same Time as Peers	Later than Peers
Sit				
Crawl				
Roll over				
Walk				
Walk up/ down stairs				
Feed self				
Dress self				
Use toilet				

How would you describe your child's motor development (running, skipping, grasping crayons/pencils) as compared to his/her peers? ____

Do you feel your child is excessively clumsy? ____

Are there or have there been any feeding or eating problems (e.g., any problems with sucking, tolerating specific food textures, swallowing, drooling, chewing, etc.)? If yes, please describe. _________________________________

____

____

From what does your child primarily drink? (e.g. cup, straw, sippy cup, bottle) _____________________________

Does your child require assistance with daily activities dressing, showering, use bathroom, feeding, etc? If yes, please describe level of assistance needed. ____

____

____

Describe your child's response to sound (e.g., responds to all sounds, tolerate loud noises, responds to loud sounds only, inconsistently responds to sounds, etc.): ____

____

Activity	Age	Earlier than Peers	Same Time as Peers	Later than Peers
Babbling (e.g., "ba, ba")				
Use first words				
Put 2-3 words together				
Make sentences				
Put sentences together				
Engage in conversation				
Understand directions				

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

□ gestures □ single words □ short phrases □ sentences

In what situations does the child have more difficulty communicating?

□ At Home □ At Daycare/Preschool □ At School □ With Friends □ Everywhere

Has the problem changed since it was first noticed? ____

Approximately how much of your child's speech do you understand?

__________ Less than 10% __________ 25% __________50% __________75% __________90% - 100%

Approximately how much of your child's speech do those less familiar with the child understand?

__________ Less than 10% __________ 25% __________50% __________75% __________90% - 100%

Behavior History:

	Often	Sometimes	Never
Does your child enjoy reading or having books read to him/her?			

Describe your child: (Check all that apply)

□ Friendly □ Shy □ Cooperative □ Independent

□ Stubborn □ Difficult to handle □ Other

Do you have any concerns about your child's behavior? If so, please describe: ______________________________

____

____

____

Speech/Language and Auditory History

Has your child had problems pronouncing certain sounds? ______________________________

____

Has your child omitted sounds or syllables in a word? ______________________________

____

Does he/she write words the same as he/she produces the words verbally? (i.e. “fumb” for thumb)______________

____

After you give directions to your child, does he/she often seem confused or need more information?

____

____

Does (or did) your child misunderstand questions? ______________________________

____

Does your child appear to tune you out in the presence of background noise?

____

Does he/she get distracted if there is competing noise in the background? ______________________________

____

Does he/she ask, “What”? or “Huh”? frequently? ______________________________

Does (or did) your child have difficulty tolerating loud noises such as airplanes or vacuums?

____

Does your child explain situations or retell stories in a manner that is out of sequence or verbose, requiring you to ask numerous questions to fully understand the intent? ______________________________

____

____

Does your child forget the names of people of things that are familiar? Does he/she frequently use vague language, referring to objects as ‘thingy’ or ‘stuff’? Does your child speak in complete sentences utilizing correct grammar?

____

____

How would you describe the child’s understanding of language, ability to express him/herself, speech productions and fluency? ______________________________

____

Educational History:

Is your child currently attending: □ Day care □ Preschool □ Elementary □ Middle □ High School

Where: ______________________________

Number of hours per week: How is he/she doing in this program? ______________________________

If applicable, does your child sit through an entire activity or class? ____

____

Has his/her teacher reported any concerns to you? Please describe. ____

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Have you reported any concerns to the teacher? Please describe. ____

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How is your child doing academically (or pre-academically)? Please comment on reading and written language.

Does he/she like current school? ____

Does he/she enjoy reading? ____

Does your child enjoy being read to? ____

How would you describe his/her handwriting (neat, sloppy, average)? _____________________________________

____

Does your child receive any special services at school? If yes, please describe: ______________________________

____

How does your child interact well with others (e.g., friendly, shy, cooperative, etc.)? _________________________

____

Do you have any concerns about your child's behaviors at school? If so, please describe: ____________________

____

Does/(or did) your child experience difficulty with any of the following?

____learning names/sounds of letters
____printing/spacing letters when writing
____sounding out words
____spelling single words
____spelling in connected writing of sentences
____copying from the board
____copying from a book
____pencil grip
____understanding what he/she reads
____writing without breaking the pencil point or hand fatigue
____following classroom directions
____staying focused in class
____sitting still in class
____remembering sequences (days of the week, months of the year)
____time concepts
____completing homework assignments
____forget books/materials or assignments at school
____forgets to turn in or loses completed work
____learning math facts
____learning new vocabulary
____misunderstanding figurative language such as idioms ("Lets put our heads together.)

Additional Information:

What changes would you like to see in your child's development within the next year? ______________________

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What do you see as your child's strengths? ____

____

____

What does your child enjoy playing with or enjoy doing? ____

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____

Is there a teacher or caregiver you would like us to contact to gather further information about your child? If yes, please identify:

Name: ________________________________ Position: _________________ Telephone: ________________

Name: ________________________________ Position: _________________ Telephone: ________________

I authorize Education & Therapy Associates to contact the above person(s) for the purpose of gathering information for my child's evaluation.

Please use this space or an extra sheet to provide any other information you would like to share about the child:

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Parent/Guardian signature