SPEECH, ACCENT, AND LANGUAGE TRAINING INSTITUTE, LLC

Child's Name: _____ Date of Birth: _____

Your Name: _____ Relationship to Child: _____

Description of the problem:

_____

_____

_____

What languages are spoken at home? _____
Is English your child's primary language? Yes/No
Who lives at home with your child? Please list the names and ages.

_____

DEVELOPMENT:

Were there any unusual conditions that may have affected the pregnancy or birth of this child? Please explain.

_____

_____

Describe any feeding problems. _____

Did your child use a pacifier/suck thumb or habitually put any other objects in the mouth? Yes/No

What age was this habit stopped _____

At what age did your child…sit up? _____walk? _____ use toilet? _____

Babble? _____Say single words?_____Use two-word combinations? _____

Use connected speech?_____
Did your child have any ear infections? If yes, at what ages and how often?

_____

MEDICAL:

Does your child have any medical conditions? Please explain. _____

_____

Has your child had any head injuries/surgeries/hospitalizations?

_____

Has your child ever experienced any time of trauma? Yes/No.

If yes, please explain.

_____

_____

Is there a history of speech, language, hearing, attention or learning problems in your family? If yes, please describe.

_____

Have any other specialists been involved in your child's care? Please list the type of specialist, when the child was seen and the findings and recommendations.

_____

_____

Is your child aware of any difficulties he/she may be having? Yes/No

If yes, how does he/she feel about it? _____

Has your child ever been evaluated by any other Speech-Language Pathologist? Yes/No

_____

EDUCATION:

What grade is your child in?

_____

Does your child receive special education services or was recommended for services?

Explain:_____

Insurance Carrier:_____ID # _____

Please feel free to provide any additional information that you feel may be helpful.

_____

_____

Thank you for your input