



SPEECH - LANGUAGE EVALUATION
PEDIATRIC CLIENT APPLICATION FORM
(Ages birth to 18 years)

****To be completed by parent/guardian and returned to the Center****

TODAY'S DATE:

IDENTIFYING INFORMATION:

Name of child to be evaluated:	
Gender Identity and/or Pronouns:	
Date of Birth:	Age:
Primary Language:	
Other languages spoken in the home:	
Who should be contacted to schedule an appointment?	

Parent/guardian #1 Name:	
Address: _____ _____ _____	Phone: Cell _____ Home _____ Work _____
Email: _____	

Parent/guardian #2 Name:	
Address: _____ _____ _____	Phone: Cell _____ Home _____ Work _____
Check if same as above <input type="checkbox"/>	
Email: _____	



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Names of Siblings:	Age:	Grade:	Learning/Speech Difficulties (Y/N & indicate type)
			Y N
			Y N
			Y N
			Y N

What cultural practices, rituals, or beliefs do you believe are important for us to be aware of?

REASON FOR REFERRAL/REQUEST:

Please describe your concern about your child's speech or hearing	
When and how did the communication challenge first occur/begin?	
Who was the first person to raise a concern about their communication?	
Is your child aware of their challenges/does your child have any concerns about their speech or hearing?	
Describe any changes in their communication, as related to the above concerns, since it began.	
What is/are their current diagnosis/diagnoses?	



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HISTORY: PREGNANCY & BIRTH (of child to be evaluated, if known)

Please describe the health of the person who carried your child:	
Before pregnancy?	
During pregnancy?	
After pregnancy?	
Please describe any issues the person who carried your child experienced while pregnant:	
Please describe any issues the person who carried your child experienced during delivery:	

Was your child full term or premature? (check one)		Full term	Premature
If premature: How many weeks?		Birth Weight:	
Did your child experience any of the following at birth?			
Bruises/anomalies in the head region	Need for oxygen		
RH incompatibility	Feeding problems		
Cerebral Palsy	Blood transfusions		
Cleft lip / palate	Other (describe):		
Did your child receive medication or treatment at birth?		Yes	No
If yes, please describe:			



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HISTORY: DEVELOPMENTAL MILESTONES

Developmental Milestone	Approximate age when first occurred
Held head up	
Sat up	
Crawled	
Fed self with spoon	
Achieved bladder control	
Toilet trained	
Walked	
First babbled	
Said first words	
First combined words	

Do you feel that your child has any of the following traits?

Trait	If yes, please describe:
Highly active	
Eating challenges (e.g., picky eating)	
Sleeping challenges (e.g., sleeping too much or too little)	
Difficulty toilet-training	
Difficulty playing with other children	
Disciplinary challenges	
Any fears or anxiety	



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Dental Concerns	
Awkwardness and lack of coordination	
Other:	

Has the client received a speech and language evaluation at another clinic?	Yes	No
If yes, please list the date of the evaluation:		
Name of Clinic:		
Has the client received prior Speech Therapy services?	Yes	No
If yes, please list the most recent dates of service:		
Name of Clinic:	Therapist's Name:	
What was the focus of these services?		
What was most helpful with these services?		
What was least helpful with these services?		
Has the client received ABA Therapy ?	Yes	No
If yes, please list the most recent dates of service:		
Name of Clinic:	BCBA's Name:	
What was most helpful with these services?		
What was least helpful with these services?		



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Has the child received Occupational Therapy ?		Yes	No
If yes, please list the most recent dates of service:			
Name of Clinic:	OT's Name:		
What was most helpful with these services?			
What was least helpful with these services?			

Has the child had a recent hearing screening or evaluation?		Yes	No
When?	Where?		
Does the child ever hear noises (ringing, buzzing, roaring, etc.) in your ears?		Yes	No
Has the child been exposed to loud sounds (gunfire, heavy machinery, etc.)?		Yes	No
Hearing loss in one/both ear(s)	right	left	both
Can hear, but not understand when people talk to me			
Prefer having the television turned louder than those around me			
Difficulty hearing in a one-to-one situation			
Difficulty hearing in groups			
Difficulty hearing on the telephone			
No difficulty hearing			
Has the child ever worn a hearing aid?		Yes	No
If yes, when?			
Does the client wear a hearing aid now?		Yes	No
If yes, approximately when was it purchased?			
Make and Model number:			
Hearing Aid Dealer:			
Does the aid seem to be operating properly at this time?		Yes	No



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Does anyone in the family have a history of the following:	
Area of Concern	Relationship to Client
Speech and Language	
Autism	
Hearing	
Traumatic Brain Injury/Concussion	
Intellectual Disability	
Cerebral Palsy	
Mental Health	
Chronic Illness:	

If applicable, please indicate the brand and model number of wheelchair(s):

Brand:	Model:
Brand:	Model:

HEALTH RECORD:

Describe the child's general health:	
Are they currently taking medication?	Yes No
If yes, please list medication(s) below:	



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Who is the primary care physician or ear-nose-throat (ENT) specialist?	
Name:	Phone:
Address:	Fax:

List and describe any hospitalization, operations, or accidents within the last ten years (indicate age at time of occurrence).	
Event	Age
Does the child have any specific medical needs we should know about (e.g., allergies, asthma, seizures) Please list:	

Has the child ever had a neurological or neuropsychological evaluation?		Yes	No
If yes, please complete the following section.			
Type of evaluation:	Date of evaluation:		
Name of clinic or hospital:	Address:		



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Are they currently receiving counseling?	Yes	No
Please indicate if they seek or avoid the following (if neither, please leave row blank):		
	Seeks	Avoids
Visual (e.g., bright colors, contrast colors, lights on/off/dimmed)		
Tactile (e.g., alerted/calmed by touch/avoid or seek textures)		
Gustatory/oral (e.g., seeks out intense flavors, crunchy foods, puts objects in mouth)		
Vestibular (e.g., swinging, spinning, bending upside down is calming/overwhelming)		
Proprioceptive (e.g., crashes into pillows/people, seeks climbing, jumping)		
Auditory (e.g., puts hands over ears, enjoys music/musical toys)		



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May we have your permission to request information about the evaluation and/or therapy mentioned above to assist us in our evaluation of your present communication challenge? Yes No

If yes, please fill out one of the attached "AUTHORIZATION FOR RELEASE OF INFORMATION" forms. If the evaluation and therapy took place in more than one place, please fill out one form for each setting.

Are there any limitations on your schedule that would make it impossible for you to come for an evaluation on any specific day? Yes No If yes, please describe:

If you have any other information which you feel would be helpful to us in preparing for your evaluation, please write it in the space provided here.

Thank you for your time in filling out this form!

Please email your completed form to SLHC@northeastern.edu, or print and mail to:

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