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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: _____ _____ _____ ☐ Check if same as above	Phone: Cell _____ Home _____ Work _____
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 SLC@northeastern.edu, or print and mail to:

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