Scottish Rite Childhood Language Center
CHILD INFORMATION FORM

DATE: ______________________

I. GENERAL INFORMATION

Name of Child: ____ **Gender:** male/female **Date of Birth:** ____________

Address: ____

____

Referred By: ____

Name of Parent/Guardian #1: ____ Relationship to Child: ______________

Address [if different from child's]: ____

Home Phone: _____________________ Cell Phone: _______________________Work Phone: _______________________

Email Address: ____ **Please circle preferred phone number for us to contact you.**

Age: ____ Education: _____________ Occupation: _____________________ Employer: _____________________________

Name of Parent/Guardian #2: ____ Relationship to Child: ______________

Address [if different from child's]: ____

Home Phone: _____________________ Cell Phone: ________________________Work Phone: ______________________

Email Address: ____ **Please circle preferred phone number for us to contact you.**

Age: ____ Education: _____________ Occupation: _____________________ Employer: _____________________________

Please indicate any pertinent legal or protective custody information: ____

____

If parents work outside the home, who cares for the child? ____

Names of Siblings/Other Children: ____ Ages: _______________

Who lives with child at home? ____

What languages are spoken at home? ____

Describe your child's problem as clearly and in as much detail as possible: ____

____

____

When did you notice the problem and what made you aware of it? ____

____

____

Please describe your goals or expectations for this evaluation/consultation/therapy: __________________________________

____

____

IF YOUR CHILD WAS ADOPTED, please indicate child's age at the time of adoption ___________.

II. PRENATAL HISTORY [Please check appropriate conditions]

Conditions of Concern During Pregnancy

_____ False labor _____ Illnesses [___ German measles; ____ viruses; ____ gestational diabetes; other: _________________________]

_____ Rh incompatibility _____ Other [i.e. accidents; medication taken; etc.]: ____

Conditions of Concern During Birth

_____ Unusually long labor _____ Medication to induce labor _____ Premature birth [gestational age at birth:___weeks]

_____ Caesarean birth _____ Breech birth _____ Forceps required

_____ Other birth complications: ____

____

Conditions of Concern Immediately Following Birth

_____ Anoxia (little or no oxygen) _____ Blood transfusion _____ Seizures

_____ Required Neonatal Intensive Care Unit _____ Sucking or swallowing problems _____ Feeding difficulties

_____ Jaundice – Treated medically? ____ No ____ Yes, with: ____ Sunlight ____ Bili-lights ____ Other (_____________)

_____ Other difficulties (Please describe): ____

III. HISTORY OF ILLNESSES / DISORDERS [Check if applicable and specify at what age your child was diagnosed]

_____ Measles _____ Chicken pox _____ Mumps _____ Seizures

_____ Meningitis _____ Encephalitis _____ Anxiety _____ Depression

_____ Autism Spectrum Disorder [Asperger's / PDD] _____ Vision Disorder _____ Sleep Disorder

_____ Sensory Integration or Regulation Disorder _____ Fine or Gross Motor Skill Delay/Disorder

_____ Attention Deficit Hyperactivity Disorder (ADHD/ADD) _____ Speech or Language Delay/Disorder

_____ Learning Disability [i.e. Reading; Mathematics; Written Expression] _____ Auditory Processing Disorder

List any other serious illnesses, disorders or injuries: ____

____

Conditions Affecting the Ear [Note most recent episodes and frequency of occurrence]

_____ Tonsillitis _____Colds _____ Sinusitis _____ Allergies _____ Asthma _____ Strep throat

_____ Problem with earwax build-up _____ Ear canal infection (swimmer's ear) _____ Dizziness or imbalance

_____ Middle ear fluid or infection _____ Eardrum perforation (Right Ear / Left Ear) _____ Tinnitus (ear/head noises)

Surgery [Check if applicable and specify age or date]

_____ Tonsillectomy _____ Eardrum ventilation tubes _____ Repair of cleft palate

_____ Adenoidectomy _____ Clipping of frenulum _____ Other (Please describe) ____________________

____

Medications

Please list all current medications [prescription/over-the-counter] and/or nutritional supplements your child is taking: _________

____

Family History [Check if applicable and indicate relationship to your child, i.e. father, elder sister, maternal brother]

_____ Speech-language disorder _____ Hearing loss _____ Attention Disorder [i.e. ADHD/ADD]

_____ Learning disability _____ Substance abuse _____ Psychological disorder (i.e. anxiety, depression)

IV. DEVELOPMENTAL MILESTONES [Note which of the following skills were delayed and the age when the skill was acquired.]

_____ Babbled _____ Used single words _____ Other ____________________

_____ Combined 2 words _____Spoke in sentences _____ Other ____________________

Check if Applicable

_____ Drools _____ Difficulty sucking, chewing, or swallowing _____ Difficulty sitting and walking

_____ Difficulty grasping objects _____ Difficulty dressing independently (i.e. putting on clothing; buttoning; zipping; etc.)

_____ Seems uncoordinated or clumsy _____ Stumbles or falls frequently _____ Difficulty using scissors

_____ Difficulty coloring inside the lines _____ Difficulty with handwriting _____ Sensitive to clothing textures, tags, etc.

Please describe any concerns you have about your child's fine or gross motor skills and/or balance/coordination: ____________

____

Sleep [Check if applicable]

_____ Snores _____ Restless/active sleeper _____ Difficulty falling asleep _____ Difficulty staying asleep

_____ Does not wake up feeling rested and ready to go in the morning _____ Sleepy during the day

Please describe any concerns you have about your child's sleep habits: ______________________________

____

Has your child ever been tested for a sleep disorder? ____ No ____ Yes, please explain: ____________________

____

V. AUDITORY BEHAVIOR [Check if applicable]

_____ Responds to name _____ Startles to loud sounds

_____ Seems to ignore sounds _____ Frightened by sounds [i.e. fire alarm; fireworks; other ______________]

_____ Hypersensitive to sounds [cries, complains, avoids related activities]

_____ Responds to sounds consistently [telephone, doorbell, car horns, airplanes, sirens]

_____ Localizes sounds [turns head in the correct direction to locate the source of sounds or voices]

_____ Often requires statements, questions, or requests repeated before answering/responding

_____ Says "Huh?" or "What?" frequently _____ Slow to follow or respond to things said to him/her

_____ Often mishears or misunderstands what is said _____ Has difficulty tuning out/ignoring background sounds

_____ Has difficulty remembering verbal directions _____ Has difficulty with phonics and speech sound discrimination

_____ Has difficulty remembering the order or sequence that he/she is told to do things.

Has your child's hearing been tested? _____No _____Yes, When? ____________ Where? ____________________

Describe results ____

VI. SOCIAL DEVELOPMENT [Check if your child exhibits these behaviors or has exhibited them in the past]

____Shows concern when separated from parent [separation anxiety]

____Adaptable to new situations

____Enjoys being with people

____Plays well with other children

____Plays with toys appropriately

____Laughs and smiles appropriately

____Able to stay with an activity to completion

____Maintains eye contact with person speaking

____Easily managed in the home

____Eats well [all consistencies]

____Understands/enjoys jokes and riddles

____Uses echolalic speech [repeats what is heard verbatim with no apparent communicative intent]

____Tends to be a loner, preferring to be by himself/herself

____Prefers to play with children younger than himself/herself

____Overactive [unable to sit still without fidgeting]

____Overly excitable ____Easily frustrated ____Gives up easily

____Easily distracted ____Short or poor attention span

____Ignores punishment ____Sensitive to being touched

____Does not establish or maintain eye contact with person speaking

____Often daydreams [stares off into space, in their own world]

____Difficulty transitioning from one activity to another

____Does not understand or use slang or figurative language

VII. SPEECH AND LANGUAGE BEHAVIOR [Please answer the following questions]

Articulation [How your child pronounces sounds]

____Yes ____No Does your child mispronounce sounds?

____Yes ____No Do you have trouble understanding your child's speech?

____Yes ____No Do other people have trouble understanding your child's speech?

____Yes ____No Does your child speak too quickly?

____Yes ____No Is your child concerned about his/her speech?

Describe any concerns you have about your child's articulation. ____

____

Language [How your child communicates]

How does your child let you know what he needs or wants? ____

How many words does your child use in a sentence? _____ Write a typical sentence: ______________________________

____

____Yes ____No Can your child name or point to body parts upon request?

____Yes ____No Can your child name or point to pictures upon request?

____Yes ____No Does your child follow simple commands? (Pick it up.)

____Yes ____No Does your child ask questions?

____Yes ____No Does your child know how to take turns in a conversation?

____Yes ____No Does your child hold appropriate phone conversations?

____Yes ____No Can your child maintain a topic in a conversation?

____Yes ____No Does your child tell stories or talk about experiences so that others can understand what happened?

____Yes ____No Does your child avoid answering questions, even though he/she may know the answer?

____Yes ____No Does your child answer questions appropriately, ***without*** delays or requiring the question repeated?

____Yes ____No Does you child follow 3-part commands, ***without*** delay or repetition? [Turn off the TV, wash your hands, then come to the table.]

____Yes ____No Does your child follow complex commands, ***without*** delay or repetition? [Before you go outside, finish your homework and put it in your backpack.]

____Yes ____No Does your child often use vague, nonspecific or incomplete references, like "stuff", "thing", "it"?

____Yes ____No Does your child have difficulty with retrieval of some common words/names when communicating?

____Yes ____No Does your child have difficulty expressing his/her thoughts completely?

____Yes ____No Does your child misuse/misunderstand/mispronounce words with similar sounds or multiple syllables?

____Yes ____No Does your child often use fillers when talking, like, "um", "uh", "you know"?

____Yes ____No Does your child often quietly repeat a question or key words to himself/herself prior to answering.

____Yes ____No Does your child talk all around a subject, add a lot of incidental information, but never get to the point?

____Yes ____No Does your child forget what he/she is talking about, or have difficulty returning to a topic if interrupted?

____Yes ____No Does your child have difficulty spontaneously correcting himself/herself after realizing that he/she misspoke or said something wrong?

VIII. FLUENCY

____Yes ____No Has anyone in your family's history had a problem with stuttering? If yes, who? ______________
____

____Yes ____No Does your child repeat sounds or words when speaking? [Ca-ca-ca-can I have the ball?]

____Yes ____No Does your child prolong sounds when speaking? [sssssnake]

____Yes ____No Does your child avoid certain situations because of his/her speech?

IX. EDUCATIONAL HISTORY

Name of school: ____ Present level in school: ___ grade

____Yes ____No Does your child have difficulty academically in school? If yes, in which subjects? ______________
____

____Yes ____No Does your child have difficulty socially in school?

____Yes ____No Does your child have difficulty completing homework assignments in a timely manner?

____Yes ____No Does your child have difficulty following verbal directions in the classroom?

____Yes ____No Does your child read at grade level? If not, at what grade level is he/she reading? ________________

____Yes ____No Does your child have difficulty with writing assignments or putting thoughts into words? If yes, please explain ____
____

____ Yes ____ No Has your child repeated a grade? If yes, which one(s)? _______________________________

(Please remember to sign Page 6 of 6.)

____Yes ____No Has your child ever received an evaluation of his/her **auditory processing** skills?

If yes, at what age: ____

Please name service provider(s): ____

____Yes ____No Has your child ever received a **speech and language evaluation or therapy** services?

If yes, at what age and for how long: ____

Please name service provider(s): ____

____Yes ____No Has your child ever received any other evaluation or therapy services? If yes, please indicate at what age, for how long, and the name of the service provider.

Occupational Therapy/Evaluation: ____

Physical Therapy/Evaluation: ____

Vision Therapy/Evaluation: ____

Psychological Evaluation/Counseling: ____

Academic/Educational Evaluation/Tutoring: ____

Other (Please describe): ____

____ Yes ____ No Currently, does your child receive any special services? If yes, please indicate whether your child receives the service(s) through his/her **school (S)**, or **privately - outside of school (O)**.

_____ Physical therapy _____ Occupational therapy _____ Speech and language therapy _____ Vision therapy

_____ Section 504 Plan _____ Resource/Collaborative SpEd _____ Self-contained SpEd classroom

_____ Reading services _____ Tutoring _____ Other (Please describe): ______________________

Please indicate your child's favorite pastimes (i.e. activities; sports; hobbies; talents; interests; etc.): ______________________

____

____

____

Please indicate any problem behaviors, unusual/intense fears, extreme dislikes, or sensitivities your child may have: _________

____

____

____

Completed by: ____

Relationship to child: ____

Thank you for taking the time to complete this form. The information you provide is extremely helpful to us as we evaluate and/or provide therapy for your child.

Scottish Rite Childhood Language Center