NEW PATIENT INFORMATION: CHILD
HEADWAY REHABILITATION

Child's Name: _____ Birth Date: _____

Parent(s) Name(s): _____ Pediatrician: _____

Address: _____ School: _____

_____ Grade: _____

Email Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

*Please asterisk(*) the best number where we may reach you.

How did you hear about us? _____

1. Indicate any concerns you have for your child in the following area(s):

☐Articulation	☐Reading Fluency	☐Poor Memory
☐Receptive Language	☐Reading Comprehension	☐Attention/Concentration
☐Expressive Language	☐Spelling	☐Loses place/Skips lines
☐Social Skills	☐Writing	☐Reversal of letters
☐Auditory Processing	☐Math	☐Motivation/Behavior
☐General Learning	☐Slow-working	☐Over-active

2. When did you first notice the problem(s) you indicated above?

3. Does anyone in your family history have a speech, language, hearing or learning problem that you are aware of?
☐ Yes ☐ No If yes, please describe:

HEALTH & DEVELOPMENTAL HISTORY

4. Did you have a normal pregnancy? ☐ Yes ☐ No Length of pregnancy: _____
Please list any complications:

5. List any medication(s) used during pregnancy:

6. Describe your child's delivery and birth: ☐typical ☐spontaneous ☐induced ☐Caesarean ☐breech ☐unusually long labor
Please list any complications:

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7. Duration of labor: _____

8. List any medication(s) used during labor:

9. What was your child's birth weight? _____

10. What was your child's condition at birth?

☐typical ☐birth injury/defect ☐jaundiced ☐breathing problem ☐low birth weight ☐other_____

11. Does your child have a history of any of the following? (Check all that apply)

☐ drooling	☐ ear tubes	☐ intubation/ventilator
☐ chronic ear infections	☐ surgery	☐ hospitalization
☐ allergies	☐ chronic or severe illness	☐ seizures
☐ asthma	☐ high or prolonged fevers	☐ head injury
☐ hearing loss	☐ reflux	☐ serious accidents

Please explain any of the above as needed:

12. Has your child ever been hospitalized? Why? How long?

13. List any medication(s) your child is currently taking:

14. What vaccinations has your child had and when did he/she receive them? Adverse reactions?

15. Has your child ever had a hearing evaluation? ☐ Yes ☐ No
If yes, list dates and results:

16. Does your child have a history of feeding problems? If yes, check all that apply:

☐ choking	☐ difficulty biting	☐ overstuffing mouth
☐ poor nursing	☐ difficulty chewing	☐ difficulty swallowing

17. Is your child a messy or picky eater? ☐ Yes ☐ No
Please list favorite foods:

Please list food allergies/sensitivities:

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18. At what age did your child attain these developmental milestones?

sitting _____ first words _____

walking _____ crawling _____

toilet training_____ first sentences_____

19. Handedness: ☐right-handed ☐left-handed ☐ambidextrous
Please also indicate if your child had taken a long time choosing a dominant hand:

SPEECH & LANGUAGE

20. Is your child reluctant to communicate or become frustrated when trying to speak? ☐ Yes ☐ No
If yes, please describe:

21. Does it seem that your child has more difficulty producing understandable speech on some days and not others, or at certain times? ☐ Yes ☐ No
If yes, please describe:

22. How would you describe your child's speech errors? ☐consistent ☐change from word to word and/or day to day

23. Approximately how much of your child's speech do you understand? ☐less than 25% ☐25% ☐50% ☐75% ☐100%

24. Can people outside the family understand your child's speech? ☐ Yes ☐ No

25. How would you describe the intonation and rhythm of your child's speech? (Check all that apply)

☐smooth	☐slow	☐soft
☐halting	☐fast	☐lacking in intonation
☐choppy	☐loud	☐lacking in pitch changes

26. Does your child play and communicate well with his/her friends and family? ☐ Yes ☐ No

27. Does your child seem to understand most of what you say or tell him/her to do? ☐ Yes ☐ No

28. Does your child…? (check yes or no for each)

	Yes	No
ask questions to gain information……	☐	☐
answer questions……	☐	☐
use age-appropriate vocabulary……	☐	☐
describe and explain……	☐	☐
take turns when talking to someone……	☐	☐
stay on topic in a conversation……	☐	☐
have difficulty putting words together in a sentence…..	☐	☐
use correct grammar, such as plurals, verb tenses, etc…	☐	☐

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29. What have you done in the past to help your child communicate? Is it effective?

VOICE AND FLUENCY

30. Is your child's voice clear? ☐ Yes ☐ No
If no, please describe:

31. Describe your child's voice. (Check all that apply, if any)

☐nasal	☐soft	☐monotone
☐denasal (sounds like he/she has a cold)	☐high-pitched	☐breathy
☐loud	☐low-pitched	☐hoarse

32. Does your child talk smoothly without repeating sounds or words? ☐ Yes ☐ No
If no, does he/she have trouble getting words out? ☐ Yes ☐ No
If yes, please describe:

AUDITORY PROCESSING AND LEARNING

33. Does your child have difficulty with any of the following? (Check all that apply)

☐memory tasks	☐remembering and following multi-step directions
☐comprehension	☐putting thoughts together
☐word retrieval	☐ learning or using new vocabulary
☐hearing	☐ hypersensitivity to loud sounds
☐ listening with background noise	☐reading
☐spelling/writing	☐ organization and planning

34. Did your child have difficulty learning early academic skills such as matching, identifying same/different, and/or knowing names of colors/shapes/numbers/letters, spatial awareness words (under, between, next to)/days of the week/ temporal words (yesterday, tomorrow, next week etc.)? ☐ Yes ☐ No
If yes, please describe:

35. Does your child receive any services at school (IEP or 504 plan) or outside help? ☐ Yes ☐ No
If yes, please describe:

36. Can your child retell a simple story in sequence? ☐ Yes ☐ No

37. Can your child identify steps to complete a simple task? (e.g., brushing teeth, setting the table) ☐ Yes ☐ No

38. Did your child having difficulty learning nursery rhymes or the concept of rhyming? ☐ Yes ☐ No

39. Does your child appear to attend to your face when listening? ☐ Yes ☐ No

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40. Does your child appear to become easily distracted when listening? ☐ Yes ☐ No

41. Does your child appear to be confused when listening? ☐ Yes ☐ No

42. Does your child appear to be particularly uncomfortable in noise (as compared to same age-peers)? ☐ Yes ☐ No

BEHAVIOR

43. Does your child typically display any of the following behaviors? (Check all that apply)

☐difficulty staying on task ☐reduced or lack of interaction with others
☐tantrums ☐difficulty finishing tasks
☐passive in interactions ☐sensitive
☐very active ☐angry/acting out behavior
☐underactive ☐frustrated
☐inattentive ☐shy
☐refuses to perform tasks

Other Information:

44. Who does your child live with? (Check all that apply)

☐both parents ☐grandparents
☐mother only ☐father only
☐foster parents ☐parent + stepparent
☐other_____

45. List all siblings and ages:

46. Are languages other than English spoken in the home? ☐ Yes ☐ No
If yes, please list:

47. Has your child been evaluated by any other professional? (Check all that apply)

☐speech-language pathologist (SLP) ☐educator/teacher
☐ occupational therapist (OT) ☐ neurologist
☐ physical therapist (PT) ☐physician
☐developmental pediatrician (specialist) ☐ geneticist
☐psychologist/psychiatrist ☐ other_____

48. Has your child had previous speech-language therapy? ☐ Yes ☐ No
If yes, please list the location(s) and describe the duration and outcome of the therapy:

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49. Does your child have a diagnosis from any of the above professionals? ☐ Yes ☐ No
If yes, please list date, professional, and diagnosis for each:

50. What other concerns do you have about your child?

51. What do you consider to be your child's greatest strengths?

52. What do you use/do to motivate your child?

53. What do you hope to gain from this evaluation?

54. Do you want these evaluation results sent to another professional? ☐ Yes ☐ No
If yes, please list below (include name, profession, and fax number):

1. _____

2. _____

3. _____

Person completing this form: _____

Relationship to patient: _____

Signature: _____ Date: _____

Thank you for taking the time to fill out this form!

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