**Patient History & Registration Information**

*For Internal Use:*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient name, first and last: | | | | |  | | | | | | | | | |
| Gender/Pronouns: | |  | |
| Patient date of birth: | | | | |  | | | | | | | |
| Parent(s) name(s), first/last/pronouns: | | | | | | | | |  | | | | | | | |
|  | | | | | | | | |  | | | | | | | |
| Patient & parent billing address: | | |  | | | | | | | | | | | | | |
| Parent’s Marital Status: | | | | | | |  | | |
| Parent home phone(s): | | | | | | |  | | |
| Parent cell phone(s): | | | | | |  | | | | | |
| Parent work phone(s): | | | | | | | |  | | | | | |
| Parent email address(es): | | | | | | | |  | | | | | | | | |
| Is email a good way to correspond with you? | | | | | | | | | | |  | | | |
| Do you give us permission to transmit information regarding your child’s speech therapy (updates, reports) via unencrypted email? (yes/no) | | | | | | | | | | | | | | | |  | |
| Names/ages of siblings or others living in the home: | | | | | | | | | | | | | | | | |
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| Reason for referral & your primary concerns? | | | | | | | | | | | | | | |
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| Primary care physician/pediatrician clinic address/phone: | | | | | | | | | | | | | | | |
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**Responsible Party/Insured’s Information**

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| Name/Relationship of  responsible party/Primary Subscriber: | | | | | | | | |  | | | | | |
| Birthdate: | |  | | | | |
| **Primary Insurance**: | | | | | | |  | | | | | | | |
| ID/Policy Number: | | | |  | | | |
| Group Number: | | | |  | | | |
| Social Security Number: | | | | |  | | | | |
| Employer & Occupation: | | | | |  | | | | | | | | | |
| Insurance claim phone number: | | | | | |  | | | | | | |
|  | & address: | |  | | | | | | | | | |
| **Secondary Insurance,** if applicable: | | | | | | |  | | | | | | | |
| Primary subscriber if different than above: | | | | | | | | | | |  | | | |
| Primary subscriber date of birth, if different than above: | | | | | | | | | | | | | |  |
| Employer & Occupation if different than above: | | | | | | | | | | | |  | | |
| Policy Number: | | | |  | | | |
| Group Number: | | | |  | | | |
| Insurance claim phone number: | | | | | |  | | | | | | |
|  | & address: | |  | | | | | | | | | |

**History Information: Medical/Birth History**

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| Were there any problems during pregnancy or difficulties at birth? | | | | | | |  | | |
| If yes, please explain: |  | | | | | | | | |
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| Has your child been hospitalized at any time? | | | | |  | | | | |
| If yes, please explain: |  | | | | | | | | |
|  | | | | | | | | | |
| Has your child’s vision been tested? | | |  | | | | | | |
| When/Where/Results: |  | | | | | | | | |
|  | | | | | | | | | |
| Has your child’s hearing been tested? | | | |  | | | | | |
| When/Where/Results: |  | | | | | | | | |
|  | | | | | | | | | |
| Is there a history of allergies, colds, ear infections, illnesses or injuries? | | | | | | | | |  |
| If yes, please explain: |  | | | | | | | | |
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| Are there any diagnosed mental, physical or emotional disabilities? | | | | | |  | | | |
| If yes, please explain: |  | | | | | | | | |
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| Please list any medications your child is currently taking: | |  | | | | | | | |
|  | | | | | | | | | |
| Is there a family history of speech, language or learning difficulties? | | | | | | | |  | |
| If yes, please explain: |  | | | | | | | | |

**Developmental/Learning History:**

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| Has your child had prior evaluations (e.g., speech-language pathologist, occupational therapist, physical therapist, neurologist, psychologist or other professional)? | | | | | | | | | | | |
| If yes: Where/When/Results? | | | | |  | | | | | | |
| Is your child currently receiving speech/language therapy? | | | | | |  | | | | | |
| If yes: Where/how often? | | | | | |  | | | | | |
| What school does your child attend? | | | | | |  | | | | | |
| Grade level: | | |  | | |
| What feedback have you been given from your child’s school or daycare regarding your child’s participation/skills? | | | | | | | | | |
|  |  | | | | | | | | | | |
| Please describe any difficulties in: | | | | | | | | | | | |
|  | Self Help skills (dressing, washing, brushing teeth, etc.): | | |  | | | | | | | |
|  |  | |  | | | | | | | | |
|  | Fine Motor skills: | |  | | | | | | | | |
|  | | | | | | | | | | | |
|  | Gross Motor skills: | |  | | | | | | | | |
|  | | At what age did your child walk unassisted? | | | | | | |  | | |
|  | | | | | | | | | | | |
|  | Oral Habits (drooling, etc.): | | | |  | | | | | | |
|  | | Does/did your child use a pacifier? | | | | | |  | | |
|  | | If yes, at what age did they stop? | | | | | |  | | |
|  | | Does/did your child suck their thumb? | | | | | |  | | |
|  | | If yes, at what age did they stop? | | | | | |  | | |
|  | Eating/Drinking (inadequate chewing, poor bite size control, choking, etc.): | | | | | |  | | | | |
|  | | | | | | | | | | | |
| Please list a few of your child’s favorite snacks: | | | | | | | | | | | |
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| How does your child’s overall balance/coordination seem to you? | | | | | | | | | | | |
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| Is your child toilet trained, or in process? | | | | | | | |  | | |
|  | | | | | | | | | | |
| Is your child overly sensitive to touch, noise, clothing, etc.? | | | | | | | | | |  |
| If yes, please explain: | |  | | | | | | | | |
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| **Speech-Language History:** | | | | | | | | | | |
| What is your child’s primary language? | | | | | |  | | | | |
| Any other languages? | |  | | | | | | | | |
|  | | | | | | | | | | |
| At what age did your child: | | | | | |  | | | | |
|  | Begin to babble – | |  | | | | |
|  | Imitate sounds – | |  | | | | |
|  | Say first word(s) – | |  | | | | |
|  | Put 2 words together – | |  | | | | |
|  | Use longer sentences – | |  | | | | |
| Was your child unusually quiet as a baby? | | | | | | |  | | | |
| How does your child typically let you know what they want? (tells me verbally; tries to use word(s); points or looks at what they want; takes my hand & leads me to things) | | | | | | | | | | |
|  |  | | | | | | | | | |
| How does your child typically let you know  they understand what you’re saying? | | | | | | | | |  | |
|  | | | |
| How much do you understand of what your child says? | | | |  | | | | | | |
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| How much do others understand? | | | | |  | | | | | |

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| --- | --- | --- | --- | --- | --- |
| How does your child react when others do not understand them? | | | | | |
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| Do you have concerns regarding stuttering? | | | | |  |
| If yes, please explain: | |  | | | |
|  | | | | |  |
| Do you have concerns regarding your child’s social or play skills? | | | | |  |
| If yes, please explain: | |  | | | |
| What are some of your child’s favorite toys and/or activities? | | | | | |
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| What are your child’s strengths? | | | | | |
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| What are the most common behavioral challenges that you have with your child? | | | |  | |
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| What strategies have you used and what seems to be most effective? | | |  | | |
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| Is there anything else you would like us to know about your child, or your family? | | | |  | |