Keystone THERAPY SERVICES

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Finding the Key to Communication…

Please fill out this form as completely as possible. The information will help us understand your child's present communication problems and will aid us in planning appropriate testing and therapy procedures. ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INFORM US IF AT ANY TIME THIS INFORMATION CHANGES.

I. Case Information

Child's name: _____ Nickname: _____ Grade: _____

Date of Birth: _____ Age: _____ Gender: Male _____ Female _____

Father's name: _____ Mother's name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Home Phone: _____ Work: _____ Cell: _____

Email address: _____

Parent's Marital Status: Single ___ Married ___ Divorced: ___ Widowed: ___

Please describe why you are having your child seen for a speech language evaluation (e.g. voice, stuttering, expressive/receptive language delay, articulation, reading difficulty, etc): _____

_____

_____

_____

How did you hear about Keystone Therapy services: _____

_____

_____

II. Family History

Please list members of family living in the home: _____

_____

_____

_____

Are there any incidences of any of the following conditions among the child's family/close relatives (maternal and paternal)? When answering yes, please explain.

1. Speech problems: yes no Explain: _____
2. Hearing problems: yes no Explain: _____
3. Learning disabilities: yes no Explain: _____
4. Seizure disorder: yes no Explain: _____
5. Mental retardation: yes no Explain: _____
6. Autism spectrum: yes no Explain _____

III. Birth History

Was there anything that happened during the mother's pregnancy that may affect your child's speech and language development? Yes (please explain} No

_____

_____

The baby was pronounced "healthy" at birth? Yes No (Please explain)

_____

_____

The baby experienced difficulties breathing at birth:	yes	no
The baby was described as a "blue baby":	yes	no
The baby experienced some jaundice	yes	no
The baby was placed on a feeding tube:	yes	no
Mother and infant were discharged separately from hospital:	yes	no

Did your child experience any early feeding/swallowing problems (weak suck, turning "blue" while attempting to nurse, projectile vomiting, choking, lack of appetite, early fatigue, milk coming out nose while nursing, etc_____

_____

_____

_____

IV. Medical History

Child's Pediatrician/Family Doctor_____

Address: _____

Please list any medications your child takes regularly (including medication for behavior or attention control). Please list purpose of the medication: _____

_____

_____

_____

Is your child currently (or recently) under a physician's care? If yes, please explain. _____

_____

_____

Does your child have any known allergies to food or to his /her environment? If yes, please explain: ____

_____

_____

Does your child have any medical diagnoses? (e.g., ADD, autism, dyslexia)? If yes, please list: _____

_____

_____

_____

Does child have a history of ear infections?	Yes	No	Dates: _____
P/E tubes:	Yes	No	Dates: _____
Frequent colds/sinus infections?	Yes	No	Dates: _____
Bronchitis/Pneumonia?	Yes	No	Dates: _____
Drainage from ear?	Yes	No	Dates: _____
Tonsils/Adenoids removed?	Yes	No	Dates: _____

Had child experienced any of the following? Please explain all "yes" responses below:

1.	Visual Difficulties:	Yes	No
2.	High fevers lasting longer than 1 day	Yes	No
3.	Seizures/Convulsions	Yes	No
4.	Tuberculosis	Yes	No
5.	Asthma	Yes	No
6.	Hospitalization	Yes	No
7.	Surgery	Yes	No
8.	Encephalitis	Yes	No
9.	Head Injury	Yes	No
10.	Swallowing/Chewing problems	Yes	No
11.	Other	Yes	No

Please explain any "Yes" answers:_____

_____

_____

_____

V. Developmental History

Did your child:

Hold his/her head up by 4 months:	Yes	No
First crawl by 12 months?	Yes	No
First walk alone by 16 months:	Yes	No
Was toilet trained by 3 years:	Yes	No
First sit alone by 12 months?	Yes	No
First ate solid food by 12 months?	Yes	No
Fed self by 2 years?	Yes	No
First use scissors by 3 years?	Yes	No
First grasped crayon/pencil (thumb and finger) by 3 years?	Yes	No

Please describe your child's gross motor skills (Coordinated, clumsy, falls a lot, slow, etc) while walking, running, climbing, riding bikes, roller skating, etc:_____

_____

_____

_____

Please describe your child's fine motor skills while attempting to color, write, draw, cut with scissors, feed him/herself with utensils, etc:_____

_____

_____

_____

VI. Speech and language Information:

Did child cry normally (to communicate pain, fear, discomfort, loneliness)?	Yes	No
Did your child begin:		
Cooing/Babbling by age 4 months:	Yes	No
Respond to name/peek a boo by 8 months:	Yes	No
Use jargon by 12 months:	Yes	No
Imitate sounds by 12 months:	Yes	No
Saying his first words by 15 months:	Yes	No
Saying 2 words together by 24 months:	Yes	No
Using short sentences by 36 months:	Yes	No

Please estimate how many words your child presently uses:_____

Has speech/language development ever been interrupted or reversed? If so, please explain:_____

_____

_____

_____

Has there been a change in the child's speech/language over the last 6 months:_____

If yes, please explain:_____

_____

_____

How does child communicate with you/siblings/peers? (e.g. pointing, gesturing, grunting, words):_____

_____

_____

_____

Please give two to three examples of your child's comments/communication that are typical at this time:_____

_____

_____

_____

_____

Indicate with a checkmark any items that are difficult for your child:

___ Eating a variety of foods
___ Following directions or routines
___ Answering questions
___Singing songs/ reciting nursery rhymes
___ Recognizing "common" words
___ Thinking of words for things
___ Rhyming
___ Telling Stories
___ Receiving/giving hugs
___ Understanding what he/she hears
___ Speaking in organized or grammatically correct sentences
___ Pronouncing words correctly
___ Stating sounds of letters
___ Writing his/her name
___ Getting his/her point across
___ Understanding concepts of time (seasons, day/night, hours)
___ Self-Calming
___ Keeping shoes on
___ Eye-Hand Coordination
___ Blowing bubbles
___ Using a straw
___ Keeping hands to him/herself

VII. Educational History

Name of School/Daycare:_____ Present grade:_____
Please list your child's school/daycare schedule:_____

_____

Has your child been kept back at any grade level? Yes No
If, yes, which grade and why?_____

Is your child currently receiving special education services through the school system? Yes No
If yes, what area is your child served (e.g. resource, speech only, etc)?_____

_____

Does he/she have a current IEP? Yes (*please provide current copy*) No

Check any/all areas of difficulty:

___ Speech
___ Reading
___ Attention
___ Math
___ Writing sentences/paragraphs
___ Spelling
___ Study habits
___ Fine motor (e.g. cutting, buttoning)
___ Organization
___ Handwriting

VIII. Diagnostic information:

Please provide copies of any test results.

Has your child received an educational evaluation: Yes No
If yes, when and please name school district: _____
Has your child received a psychological evaluation: Yes No

If yes, when was testing conducted? _____
Has your child received speech language evaluation and/or therapy in the past? Yes No

If yes, date of most recent evaluation? _____
If yes, How long has your child received speech therapy services? _____
Where?_____
Name of therapist/agency? _____

_____

IX. Child Interest

Comments: Please make any other comments which you feel would be helpful or important in our endeavor to assist with your child's needs:_____

_____
_____
_____
_____
_____
_____
_____
_____

Does your child have any specific interest that may be beneficial to know in order to prepare for our time together?_____

_____

_____

_____

X. Behavioral History

Please check all that describe your child:

- ☐ Friendly
- ☐ Easy-going
- ☐ Plays well with other children
- ☐ Aggressive/destructive
- ☐ Has temper tantrums
- ☐ Unpredictable
- ☐ Sleeps well
- ☐ Eats well
- ☐ Plays alone for reasonable amount of time
- ☐ Doesn't like to be touched
- ☐ Talkative
- ☐ Clumsy
- ☐ Distractible/short attention span
- ☐ Easily frustrated
- ☐ Restless
- ☐ Quiet
- ☐ Attentive
- ☐ Willing to try new activities
- ☐ Will not eat certain textures
- ☐ Will not touch certain textures
- ☐ Overly sensitive emotionally
- ☐ Still uses pacifier/ sucks thumb
- ☐ Impulsive/impatient
- ☐ Difficulty sleeping
- ☐ Hyperactive
- ☐ Doesn't like to be read to
- ☐ Poor memory
- ☐ Defiant
- ☐ Stubborn
- ☐ Bites nails
- ☐ Cannot easily shift from one activity to another
- ☐ Bad-tempered
- ☐ Cries easily
- ☐ Wets bed
- ☐ Withdrawn shy
- ☐ Daydreams often
- ☐ Separation difficulties
- ☐ Poor eye contact
- ☐ Cooperative
- ☐ Has nightmares
- ☐ Grinds teeth
- ☐ Mouth breather
- ☐ Snores
- ☐ Sensitive to sounds

Thank you for allowing Keystone Therapy Services to be a part of your child's "world"! I consider it a blessing to be able to make a difference in your child's life!