SPEECH LANGUAGE & LEARNING SERVICES
LEARNING TO COMMUNICATE FOR SUCCESS IN LIFE!

2384 Highway 287 N. Suite 212
Mansfield, TX 76063
Office: 682-400-8132
Fax: 682-400-8235
Email: sllstx.office@gmail.com

Patient Information:

Name: _____
Date of Birth: _____
Gender: _____ Grade:_____

Address: _____
City, State, Zip: _____
Home Phone: _____
Best number to reach you? _____

Parents or Guardians:

Child lives with: ☐ Mother ☐ Father ☐ Other_____

Mother's Name: _____
DOB _____Social Security#_____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Email:_____
Mother's Occupation:_____
Employer:_____
Work phone: _____
Do you communicate by text? ☐ YES ☐ NO

Father's Name: _____
DOB _____Social Security #_____
Address:_____
City, State, Zip:_____
Home Phone: _____
Cell Phone: _____
Email: _____
Father's Occupation:_____
Employer:_____
Work phone: _____
Do you communicate by text? ☐ YES ☐ NO

Emergency Contacts: Include people who may be involved in our sessions or may provide emergency support

Name:_____
Home Phone: _____
Relationship to client:_____
Cell Phone: _____

Name:_____
Home Phone: _____
Relationship to client:_____
Cell Phone: _____

Referral Information:

Referred by: _____ Phone: _____ Fax: _____

Primary Care Provider/Pediatrician:_____ Address, City Zip:_____
Phone: _____Fax: _____ Email: _____

Primary Insurance:

Plan:_____ Subscriber:_____ Member ID #:_____ Group #_____
Subscriber's Date of Birth:_____ Gender:_____Employer:_____
Business address:_____
Billing Address:_____ Phone: _____Fax: _____

Secondary Insurance:

Plan:_____ Subscriber:_____ Member ID #:_____ Group #_____
Subscriber's Date of Birth_____ Gender_____Employer_____
Business address:_____
Billing Address:_____ Phone: _____Fax: _____

What Languages are spoken in the family?
Primary:_____ Secondary:_____ Others:_____ Need Interpreter? ☐ Yes ☐ No

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Family Information:

Others living in the same home:

Names	Gender	Ages	Relationship

Other persons special to your child:

Names	Gender	Ages	Relationship

Educational Experience:

Preschool Experience? ☐ Yes ☐ No If "yes", how long?_____ Where?_____

School Attending?_____ School District: _____
Current grade level: _____ Retained or "held back"? ☐ Yes ☐ No If "yes" what grade?_____

Does your child receive Special Education services? (Have an IEP or ARD?)
☐ Yes ☐ No, If "Yes", please indicate type of services & placement: _____

Does your child **currently** receive Speech Language Pathology or therapy services?
☐ Yes ☐ No, If "Yes", where? _____ With Whom? _____

Has your child **previously** received Speech Language Pathology or therapy services?
☐ Yes ☐ No, If "Yes", where? _____ With Whom? _____

Describe your child's speech-language problem: _____
_____
_____

What do you think may have caused the problem? _____
_____

Has the problem changed since it was first noticed? Please describe: _____
_____

Prenatal and Birth History

Mother's general health during pregnancy (illness, accidents, medications, etc.): _____
_____
Length of pregnancy: _____ Length of Labor: _____ Complications? _____
Birth weight: _____ Length: _____ General Condition: _____
Baby's position at delivery: ☐ head first ☐ feet first ☐ breech ☐ posterior
Type of delivery: ☐ vaginal ☐ routine C-section ☐ emergency C-section
Length of hospital stay: _____

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Developmental Milestones
Did your child:

Babble? ☐ No ☐ Yes, Age started ____
Use single words? ☐ No ☐ Yes, Age started ____
Ask questions? ☐ No ☐ Yes, Age started_____

Combine words? ☐ No ☐ Yes, Age started _____
Use full sentences? ☐ No ☐ Yes, Age started ____

When did your child start crawling? Age_____

When did your child take his/her first steps? Age_____ Start Walking? Age_____

Are there any other speech, language, learning, or hearing problems in your family? ☐ No ☐ Yes
Describe: _____ Relationship: _____

Describe your child's temperament:
As an infant (i.e.: colic, fussy, quiet, active, etc): _____
_____

Current temperament (social, quiet, active, loud, etc): _____
_____

Child's Health History
Please list any Allergies (i.e. Food, seasonal, medications, insect bites, etc.): _____

List all medications your child is currently taking (include dose & reasons for taking them): _____
_____

Describe any negative reactions or side effects your child is experiencing, which you believe is related to the medications?
_____

Is there anyone who smokes around your child? ☐ No ☐ Yes: how often? _____

Provide the approximate **ages** at which your child has experienced the following conditions (**or frequency of experience**):

☐Adenoidectomy_____
☐Allergies_____
☐Asthma_____
☐Chicken Pox_____
☐Croup_____
☐Dizziness_____
☐Ear Drainage_____
☐Swimmers ear_____
☐Ear infections_____
☐Ear drum perforation_____
☐Ear tubes_____
☐Encephalitis_____
☐German Measles_____
☐Headaches_____
☐Head trauma_____
☐Hearing loss_____
☐High fever_____
☐Mastoiditis _____
☐Measles_____
☐Meningitis_____
☐Mumps_____
☐Otosclerosis_____
☐Pneumonia_____
☐Seizures_____
☐Sinusitis_____
☐Tinnitus_____
☐Tonsillectomy_____
☐Tonsillitis_____
☐Other_____

Please list dates of hospitalizations (include diagnoses obtained):_____
_____

Please list dates of surgeries and reason: _____
_____

Describe any serious accidents or injuries (please include dates):
_____
_____

Other specialists your child has seen (physicians, ENT/ORL, psychologists, neurologists, dentists, orthodontists, etc.)?
Type of specialist/s: _____ Dates: _____ Conclusions or Recommendations: _____
_____

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Immunizations: Current? ☐ Yes ☐ No: If No, have you obtained a State exemption? ☐ Yes ☐ No ☐ In Process

Describe your child's level of exposure to noise (i.e. frequency in use of headphones, iPod, TV loudness, attendance at concerts, etc.):_____

In what ways do you attempt to protect your child's hearing? _____

Has your child's Hearing been tested? ☐ No ☐ Yes: Test results? ☐ Passed ☐ Failed ☐ tympanostomy tubes in place ☐ history of tympanostomy tubes no longer in place ☐ wears hearing aids ☐ cochlear implants ☐ other results: _____

Has your child's Vision been tested? ☐ No ☐ Yes: Results? ☐ Normal/passed, Wears: ☐ Glasses ☐ Contacts ☐ Other: Please explain: _____

Eating/Swallowing History:
Does your child cough during meals? ☐ No ☐ Yes
Does your child have difficulty chewing? ☐ No ☐ Yes
Does your child have difficulty tolerating certain food textures? ☐ No ☐ Yes
Does your child chew food thoroughly before swallowing? ☐ No ☐ Yes
Does your child over-stuff his/her mouth? ☐ No ☐ Yes
Did you Breast feed? ☐ No ☐ Yes
Did you Bottle feed? ☐ No ☐ Yes
Did your child require alternative feeding methods? ☐ No ☐ Yes: ☐ NG tube ☐ PEG tube
Was there difficulty with latching? ☐ No ☐ Yes
Was there difficulty with weight gain? ☐ No ☐ Yes: ☐ current ☐ resolved: what age: _____
Did your child experience reflux? ☐ No ☐ Yes: ☐ current ☐ resolved: what age: _____
Did your child experience hyperactive gag/excessive gagging? ☐ No ☐ Yes: ☐ current ☐ resolved: what age: _____
Did your child use a pacifier? ☐ No ☐ Yes: ☐ current ☐ resolved: what age: _____
Did your child suck his/her thumb? ☐ No ☐ Yes: ☐ current ☐ resolved: what age: _____
Did your child suck on a finger or combination of fingers? ☐ No ☐ Yes: ☐ current ☐ resolved: what age: _____
Is your child a Picky eater? ☐ No ☐ Yes: please provide details: _____
_____

General Behavior:
Describe your child's attention, activity level, and behavior: _____
_____

Describe your method of discipline and your child's response to discipline: _____
_____

Provide any additional information that might be helpful in the evaluation or remediation process: _____
_____
_____

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however, you are responsible for your co-pay, deductible and/or co-insurance. I agree that the information supplied on this form is accurate, current, and complete to the best of my knowledge. I hereby assign Speech Language & Learning Services any insurance or other third-party benefits available for healthcare services provided to me. I understand that ***Speech Language & Learning Services has the right to refuse or accept assignment of such benefits***. If these benefits are not assigned to Speech Language & Learning Services, I agree to immediately upon receipt forward to Speech Language & Learning Services all health insurance and other third-party payments I receive for the services which were rendered to me by Speech Language & Learning Services.

Person completing form (print): _____ Relationship to client: _____

Signature: _____ Date: _____