



**SPEECH  
LANGUAGE &  
LEARNING  
SERVICES**

LEARNING TO COMMUNICATE FOR SUCCESS IN LIFE!

1285 N. Main St., Suite 101-1  
Mansfield, TX 76063  
Office: 682-400-8132  
Fax: 682-400-8235  
Email: slstx.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:

<u>Names</u>	<u>Gender</u>	<u>Ages</u>	<u>Relationship</u>

Other persons special to your child:

<u>Names</u>	<u>Gender</u>	<u>Ages</u>	<u>Relationship</u>

**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: \_\_\_\_\_