Speech & Language Evaluation Information

Child's Name _____ Date of Birth _____
Primary Doctor _____ Clinic _____
Person completing form _____ Relationship to Child _____
Parent's phone # _____ E-mail _____

Evaluation Considerations

What concerns do you have? Please check all that apply

◯ Child is not verbal ◯ Concerned that child does not talk as much as peers ◯ Voice
◯ Can't understand what child says ◯ Fluency (stuttering) ◯ Feeding concerns
◯ Child doesn't seem to understand what you're saying
◯ Child can't put what they want to say into words ◯ Sentence structure is confusing
◯ Augmentative/Alternative Communication device is being considered
◯ Social skills/pragmatic language

Medical History

Child was born at _____ weeks, weighing _____ lbs, _____ oz
Was the child hospitalized after birth? ◯ No ◯ Yes (Please describe):
_____

Please check all past or current medical conditions that apply:

◯ Hearing loss ◯ Suspected hearing loss ◯ Cochlear implants ◯ Feeding tube
◯ Recurrent ear infections ◯ PE tubes ◯ Tonsillectomy ◯ Tongue clipped ◯ Anxiety
◯ Seizure disorder ◯ Cleft lip/palate ◯ ADHD ◯ Autism Spectrum Disorder
◯ Other: _____

Does the child have any other medical condition(s) or allergies? ◯No ◯Yes
Please list: _____
Has the child ever been hospitalized or had any medical procedures? ◯No ◯Yes
Please list: _____
Is the child currently taking any medications? ◯No ◯Yes (Please list):

Medication	Dose/Frequency	What it treats

Are there any other precautions or restrictions that I should be aware of? ◯ No ◯ Yes (Describe):
_____
Please list any current medical conditions or diagnoses that you child has been given:
_____

Is the child currently under the care of any of the following specialists?: (Check all that apply)

◯Cardiologist ◯Audiologist ◯ENT ◯Psychiatrist ◯ Psychologist ◯Pulmonologist

◯Endocrinologist ◯Geneticist ◯Physical Therapist ◯Occupational Therapist ◯Neurologist

◯ABA Therapist ◯Other: _____

Do you give consent to Kim Lemley, M.S. CCC-SLP to discuss your child's evaluation or treatment with any of the specialists listed above? If so, please provide the names of all specialists that you give consent to release information to: _____

_____

Developmental History:

Please list approximate ages for the following developmental milestones:

Began babbling _____

Crawled _____

Stopped using pacifier _____

Sat independently _____

Finger fed _____

Used spoon/fork _____

Stopped using bottle _____

Ate table food _____

Walked _____

Used sippy cup _____

Used open cup _____

First word _____

Feeding Information:

My child eats (check all that apply): ◯Table food with the rest of the family ◯Pureed diet

◯Sensory diet ◯Gluten free diet ◯Casein free diet ◯Stage 3 baby foods

◯Stage 2 baby foods ◯Formula only ◯Breast fed only ◯Thickened liquids

◯Whatever I can convince him/her to eat

If your child has difficulty with the textures of certain foods, please describe:

_____

_____

_____

Educational Information:

Child is currently enrolled in: ◯Preschool ◯Mother's Day Out ◯Homeschooled

◯Developmental preschool ◯Private School ◯Public School (Please list school and grade level):

_____

Does your child receive any of the following through his/her school?

◯Speech Therapy: _____ times a week

◯Occupational Therapy: _____ times a week

◯Physical Therapy: _____ times a week

◯Have an IEP in place

Do you give your consent to Kim Lemley, M.S. CCC-SLP or another member of the Pitts & Associates staff to discuss your child's evaluation and/or treatment with your child's school teacher, therapist, or other employee? ◯No ◯Yes If so, please list: _____

Additional Information:

Has your child ever been evaluated for speech therapy before? ◯No ◯Yes

In therapy, your child is working on: _____

Is your child enrolled in other therapy services: ◯No ◯Yes (please list): _____

Is your child enrolled in any community sports or other activities? ◯No ◯Yes

Please list: _____

What are your child's favorite games/toys/activities?

_____

_____

Is there any other additional information I need to know to work with your child?

_____

_____

_____

Authorization to test and/or treat

I authorize Kim Lemley, M.S. CCC-SLP, to evaluate and treat my child,
_____ (child's name).
I understand that I will be responsible for payment at the time of service, as well as a possible fee for missed visits and late cancellations. I authorize communication between Kim Lemley or a billing specialist from Pitts & Associates and my insurance company for coordination of payment. I authorize verbal and written communication between Kim Lemley and my child's doctor for coordination of care.

_____ _____

Parent/Guardian signature Date

_____

Parent/Guardian printed name