

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 _____ | Stopped using bottle _____ |
| Crawled _____ | Ate table food _____ |
| Stopped using pacifier _____ | Walked _____ |
| Sat independently _____ | Used sippy cup _____ |
| Finger fed _____ | Used open cup _____ |
| Used spoon/fork _____ | 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