

Other Languages in the home:

Is there a language other than English spoke in the home? <input type="checkbox"/> No (skip to next section) <input type="checkbox"/> Yes (which one?):	
Does the child speak the language? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who in the home speaks the language?
Does the child understand the language? <input type="checkbox"/> Yes <input type="checkbox"/> No	Which language is the child's preferred language?

Other Needs:

Are there any cultural norms that you would like us to know about that may affect delivery of services for your child? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain):
Are there any religious or spiritual needs that would be helpful to know that may affect delivery of services for your child? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain):

Birth History

Was there anything unusual about the pregnancy or birth? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain):	
How many weeks was the pregnancy?	How old was the mother when the child was born?
Did the mother have any health problems during pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain):	
After the birth, did the baby require additional hospital stay? <input type="checkbox"/> No <input type="checkbox"/> Yes (how long): _____ Explain:	

General Medical History

Primary Care Doctor:	Phone Number:
Other Specialists:	
Are Immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please list any medications your child takes regularly:
Has your child had any of the following?	
<input type="checkbox"/> adenoidectomy <input type="checkbox"/> feeding troubles <input type="checkbox"/> sinusitis <input type="checkbox"/> allergies; Type? _____	
<input type="checkbox"/> flu <input type="checkbox"/> sleeping difficulties <input type="checkbox"/> breathing difficulties	
<input type="checkbox"/> head injury <input type="checkbox"/> stomach/bowel trouble <input type="checkbox"/> chicken pox	
<input type="checkbox"/> heart trouble <input type="checkbox"/> thumb/finger sucking <input type="checkbox"/> colds <input type="checkbox"/> frequent fevers	
<input type="checkbox"/> tonsillectomy <input type="checkbox"/> meningitis <input type="checkbox"/> ear infections; How often? _____	
<input type="checkbox"/> tonsillitis <input type="checkbox"/> ear tubes <input type="checkbox"/> scarlet fever	
<input type="checkbox"/> vision problems <input type="checkbox"/> encephalitis <input type="checkbox"/> seizures <input type="checkbox"/> other: _____	
Any other accidents or injuries?	
Is your child currently (or recently) under a physician's care? <input type="checkbox"/> No <input type="checkbox"/> Yes (explain):	

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

sat alone	babbled	said first words	put two words together
spoke in short sentences	walked	toilet trained	grasped crayon/pencil

Please check which words describe your child:

<input type="checkbox"/> affectionate	<input type="checkbox"/> demanding	<input type="checkbox"/> playful	<input type="checkbox"/> overactive	<input type="checkbox"/> calm
<input type="checkbox"/> good disposition	<input type="checkbox"/> shy	<input type="checkbox"/> angry	<input type="checkbox"/> stubborn	<input type="checkbox"/> sad
<input type="checkbox"/> curious	<input type="checkbox"/> hard to comfort	<input type="checkbox"/> likes people	<input type="checkbox"/> confident	<input type="checkbox"/> fearful
<input type="checkbox"/> joyful	<input type="checkbox"/> fearless	<input type="checkbox"/> other:		

Do you have any concerns about your child's (please check which apply):

Height	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure	Vision	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure
Weight	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure	Head Size	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure
Hearing	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure	Movement	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure
Behavior	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure	Speech/Language	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure
Eating	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure	Nutrition	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure
Sleeping	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure	Sensory Processing	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> not sure

Sensory:

Does your child have any strong preferences and/or consume limited food consistencies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child crash, bump, jump, or seek physical activities outside what appear typical?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child wear limited clothing textures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does your child have sensitivities to lights, sounds, or strong smells?
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
			<input type="checkbox"/> No

Speech & Hearing History

Do you feel your child has a speech problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please check areas of concern for speech/language:

<input type="checkbox"/> articulation (speech sounds)	<input type="checkbox"/> apraxia/motor speech	<input type="checkbox"/> speaks in short sentences/phrases
<input type="checkbox"/> understanding of language (auditory comprehension)		<input type="checkbox"/> social skills/pragmatics
<input type="checkbox"/> expressive language/vocabulary	<input type="checkbox"/> stuttering (fluency)	<input type="checkbox"/> use of a communication device (AAC)
<input type="checkbox"/> voice disorder	<input type="checkbox"/> dysphagia (swallowing)	<input type="checkbox"/> hearing impairment/cochlear implant
<input type="checkbox"/> traumatic brain injury (attention/cognition/memory/organization)		
Has your child ever had a speech evaluation/screening?		<input type="checkbox"/> Yes
		<input type="checkbox"/> No
If yes, where and when?		
What were you told?		
Has your child ever had speech therapy?		<input type="checkbox"/> Yes
		<input type="checkbox"/> No
If yes, where and when?		

What were they working on?
Is your child receiving speech support through the school system? <input type="checkbox"/> Yes <input type="checkbox"/> No School District and Type:
Do you feel your child has a hearing problem? <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:
Has your child ever had a hearing evaluation/screening? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, where and when?
What were the results?
Has your child ever received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, ear, nose, throat doctor)? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please describe:
Is your child aware of, or frustrated by, any speech-language difficulties?
What do you see as your child's most difficult problem in the home?
What do you see as your child's most difficult problem in school?
What are some questions you would like answered?

* Please send or bring any Speech-Language evaluations, OT/PT evals, IFSP/IEPs, or any other documents that would help us evaluate and plan for your child.

Current Speech-Language-Hearing

Does your child...

Repeat sounds, words, or phrases over and over?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Follow simple directions ("shut the door, "get your shoes")?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Understand what you are saying?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Respond correctly to yes/no questions?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Retrieve/point to common objects upon request (ball, cup, shoe)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Respond correctly to who/what/where/when/why questions?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sleeping	<input type="checkbox"/> yes	<input type="checkbox"/> no

Does your child communicate using...

<input type="checkbox"/> body language	<input type="checkbox"/> Sounds (vowels, grunting)	<input type="checkbox"/> words (shoe, doggy)	<input type="checkbox"/> 2 to 4 word sentences
<input type="checkbox"/> sentences longer than four words	<input type="checkbox"/> other:		

Behavioral characteristics:

<input type="checkbox"/> cooperative	<input type="checkbox"/> restless	<input type="checkbox"/> attentive	<input type="checkbox"/> poor eye contact	<input type="checkbox"/> willing to try new activities
<input type="checkbox"/> separation difficulties	<input type="checkbox"/> withdrawn	<input type="checkbox"/> easily distracted/short attention	<input type="checkbox"/> inappropriate behavior	
<input type="checkbox"/> easily frustrated/impulsive	<input type="checkbox"/> stubborn	<input type="checkbox"/> self-abusive behavior		

School History

If your child is in school, please answer the following:

Name of School	Grade in School
What are your child's strengths and/or best subjects?	
Is your child having difficulty with any subjects?	
Is your child receiving help in any subjects?	

Additional Comments:

Submit Form:

Mail: Calvin Speech & Hearing Clinic,
Calvin University
3201 Burton St SE
Grand Rapids, MI 49546

Fax: 616-469-1355 By email: spaud@calvin.edu Clinic phone: 616-526-6070

For driving directions to our clinic (North Hall): <http://www.calvin.edu/map/>

For more information about our clinic: www.calvin.edu/go/SpeechClinic

My child is available on the following days (please check all that apply):

Monday (AM) ____ Tuesday (PM) ____ Wednesday (AM) ____ Wednesday (PM) ____ Thursday (PM) ____

Pediatric sessions are on Monday and Wednesday mornings. Afternoon sessions are available on a limited basis.

The Calvin University Speech Pathology and Audiology Program is committed to the principle of equal opportunity. We do not discriminate on the delivery of professional services on the basis of race, color, religion, sex, national or ethnic origin, disability, age, sexual orientation, genetic information, citizenship, status as a covered veteran, or other characteristics protected by federal, state, or local statute or ordinance.