C.A.P. SPEECH THERAPY

communicate • aspire • play

**PATIENT INFORMATION FORM**

PATIENT NAME: _____ DOB: _____

SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MEDICAL DIAGNOSIS: _____

MOTHER NAME: _____ DR LIC #: _____

PHONE: _____ CELL: _____WORK PHONE: _____

EMAIL: _____

FATHER NAME: _____DR LIC #: _____

PHONE: _____CELL: _____ WORK PHONE: _____

EMAIL: _____

WHO RESIDES IN YOUR CHILD'S HOUSEHOLD: _____

NEAREST RELATIVE IF UNABLE TO CONTACT YOU: _____

PHONE: _____

WHAT IS THE BEST WAY TO CONTACT YOU REGARDING APPOINTMENTS/SCHEDULING?

☐ PHONE CALL ☐ TEXT ☐ EMAIL

IF SOMEBODY REFERRED YOU (INCLUDING DOCTOR OFFICES) PLEASE PROVIDE THEIR INFORMATION, WE WOULD LIKE TO SHOW OUR GRATITUDE BY SENDING THEM A GIFT! ☺

REFERRED BY: _____ PHONE: _____

ADDRESS: _____

PHYSICIAN NAME: _____ PHONE: _____

PRIMARY INSURANCE: _____

NAME OF PRIMARY INSURED:_____

ID #: _____ D.O.B. OF PRIMARY: _____

PHONE #:_____ GROUP #: _____

**Please describe reason for evaluation:**

_____

_____

(2/3) CHILD'S NAME: _____

**THERAPY PRECAUTIONS-**Please be specific

| | Yes | No | Comments |
|---|---|---|---|
| 1. Does your child have any food allergies? Please list. | **Y** | **N** | |
| 2. Does your child have a history of seizures? If so, when did the last seizure occur? | **Y** | **N** | |
| 3. Please describe any other precautions that are not mentioned above._____ | **Y** | **N** | |

**PREGNANCY AND BIRTH HISTORY**

| | Yes | No | Comments |
|---|---|---|---|
| 1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy? Describe: | **Y** | **N** | |
| 2. Was this pregnancy full-term? If not, please give gestational age and weight at time of delivery. | **Y** | **N** | |
| 3. Were there difficulties with feeding? | **Y** | **N** | |
| 4. Did your child have difficulties sucking? | **Y** | **N** | |
| 5. Does your child have any siblings?<br>* If so, Number of siblings? _____<br>* Do siblings have any pertinent medical history or history of language disorder? _____ | **Y** | **N** | |
| 6. Please describe any pertinent birth history not mentioned above. _____ | **---** | **---** | |

**MEDICAL HISTORY**

| Has your child had any of the following: | Yes | No | Comments |
|---|---|---|---|
| 1. Frequent Ear infections | **Y** | **N** | |
| 2 Excessive vomiting or reflux. | **Y** | **N** | |
| 3. Asthma | **Y** | **N** | |
| 4. Vision problems? | **Y** | **N** | |
| 5. Hearing problems? | **Y** | **N** | |
| 6. Is your child on any medications? Please list. | **Y** | **N** | |
| 7. Please describe any pertinent medical conditions not mentioned above. _____ | **---** | **---** | |

**SENSORY HISTORY**

| Does your child have any difficulties with the following: | Yes | No | Comments |
|---|---|---|---|
| 1. Eating a variety of age appropriate foods and textures | **Y** | **N** | |
| 2. Drooling | **Y** | **N** | |
| 3. Chewing/swallowing food | **Y** | **N** | |
| 4. Tolerating tags/clothing/shoes | **Y** | **N** | |
| 5. Playing in grass, sand, or dirt | **Y** | **N** | |
| 6. Tolerating dirty hands/face when eating and/or playing | **Y** | **N** | |
| 7. Being strapped into a car seat or booster seat | **Y** | **N** | |
| 8. Tolerating hair being brushed/washed | **Y** | **N** | |
| 9. Flap hands, jump, or spin when excited? | **Y** | **N** | |
| 9. Attending to tasks? | **Y** | **N** | |
| 10. Please describe any pertinent sensory condition not mentioned above. _____ | **---** | **---** | |

(3/3) CHILD'S NAME: _____

**SPEECH AND LANGUAGE HISTORY**

| Does your child: | Yes | No | Comments |
|---|---|---|---|
| 1. Use words to communicate needs/wants | **Y** | **N** | |
| 2. Follow simple directions (e.g. "get your shoes") | **Y** | **N** | |
| 3. Follow complex directions (e.g. "push in your chair and throw away your garbage.") | **Y** | **N** | |
| 4. Mispronounce words/sounds when communicating? | **Y** | **N** | |
| 5. Repeat words when getting his/her point across (e.g. "can, can, can I go too?") | **Y** | **N** | |
| 6. Make eye contact when communicating or when talked to? | **Y** | **N** | |
| 7. Respond to his/her name when called? | **Y** | **N** | |
| 8. Play well with other peers his/her age? | **Y** | **N** | |
| 9. Play appropriately with a variety of age appropriate toys? | **Y** | **N** | |
| 10. Prefer to play with one type of toy/action figurine | **Y** | **N** | |
| 11. Please describe any pertinent speech and language condition not mentioned above. _____ | **Y** | **N** | |

**GROWTH AND DEVELOPMENT**

At what age did your child first:

Sit alone_____ Feed self finger foods_____
Crawl (hands & feet)_____ Speak first real words _____
Stand alone _____Speak first real sentences _____
Walk well _____Become completely toilet trained_____

**SCHOOL/DAYCARE HISTORY**

**(if not applicable please check: ☐ NOT APPLICABLE)**

School/Daycare name: _____Grade/Class: _____

Please describe child's performance at school/daycare. What areas/subjects does your child do well in? What areas/subjects does your child have difficulty with?

_____
_____
_____

Does your child exhibit behaviors at home or school that concern you? Please explain:

_____
_____
_____

**Parent/Guardian print name**_____

**Parent/Guardian signature**_____ **Date**: _____