CLaSS

CHILDREN'S LANGUAGE AND SPEECH SERVICES, LLC

General Information

Child's Name:_____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ Zip Code: _____

Guardian Name: _____ Age: _____

Occupation: _____ Phone: _____

Email: _____

Guardian Name: _____ Age: _____

Occupation: _____ Phone: _____

Email: _____

Referred by: _____

Brothers and Sisters (include names and ages):

_____

_____

_____

_____

What languages does the child speak? What is the child's dominant language?

With whom does the child spend most of his or her time?

Describe the child's speech-language difficulty.

How does the child usually communicate (gestures, single words, short phrases, sentences)?

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does he or she feel about it?

Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions?

Have any other specialists seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Are there any other speech, language, or hearing problems in your family? If yes, please describe.

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.).

Length of pregnancy: _____ Length of labor: _____

General condition: _____ Birth weight: _____

Circle type of delivery: head first/ feet first/ breech/ Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History

Pediatrician: _____ Phone: _____

Address:_____

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Asthma _____Chicken pox _____ Colds _____
Croup _____Dizziness_____ Draining ear _____
Ear infections _____Encephalis_____German measles _____
Headaches _____High fever _____Influenza _____
Mastoiditis _____Measles _____ Meningitis _____
Mumps _____Pneumonia _____ Seizures _____
Sinusitis _____ Tinnitus _____ Tonsillitis _____
Other _____

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify.

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl _____ Sit _____ Stand _____
Walk _____ Feed self _____ Dress self _____
Use toilet _____
Use single words (e.g., no, mom, doggie) _____
Combine words (e.g., me go, daddy shoe) _____
Name simple objects (e.g., dog, car, tree) _____
Use simple questions (e.g., Where's doggie?) _____
Engage in a conversation _____

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing)? If yes, describe.

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds).

Educational History

School: _____ Grade: _____

Teacher:_____ Email: _____

How is the child doing academically (or pre-academically)?

Does the child receive special services? If yes, describe.

How does the child interact with others (e.g., shy, aggressive, uncooperative)?

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals.

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form: _____ Relationship to client: _____

Signed: _____ Date: _____