8801 S. Olie Building 5 • Oklahoma City, OK 73139
Phone: 405-601-7192 • Fax: 405-212-4489

Client Name: ____

DOB: ____________________ Age: ______________ Gender: M F

Parent/Guardian name: ____

Street Address: ____

City, State, Zip: ____

Primary phone: ____________________ Alternate phone: ____________________

Email: ____

Referred by: ____

Reason for referral: ____

Child's Physician: ____________________ Phone: ____________________

Other doctors or specialists who provide care to this child: ______________________

____

____

Primary Insurance: ____________________ Policy#: ____________________

Insured's name: ____________________ DOB:____________________

Secondary Insurance: ____________________ Policy#: ____________________

Insured's name: ____________________ DOB:____________________

Please bring (or send prior to your evaluation) a copy of your most current insurance card, a current IEP (if applicable), prior testing results, and a doctor's order for speech therapy.

Family Background

Mother's name: ____ Age: ____________
Occupation: _________________________________ Education level: _______________________
History of Speech, Language, or Hearing Problems? Yes No
If yes, please explain: ____

____

Father's name: ____ Age: ____________
Occupation: _________________________________ Education level: _______________________
History of Speech, Language, or Hearing Problems? Yes No
If yes, please explain: ____

____

Brothers and Sisters

Name	Age	Speech, Hearing or Medical Problems

Is there a family history (parent, brothers, sisters, aunts, uncles, cousins, grandparents) of any of the following?

- Hearing loss ____
- Speech problem ____
- Prematurity ____
- Blindness ____
- Malformation of the head, neck or ears _____________________________________
- Educational difficulties ____
- Cleft palate ____
- Seizure disorder ____
- Mental illness ____
- Delayed motor development ____
- Low birth weight ____
- Other ____

Who is currently living in the home with your child?
___ biological mother ___ biological father ___ adoptive parents
___ stepmother/father ___ brothers/sisters ___ grandparents
___ foster parents ___ other ____

Is any language other than English spoken in the home? ________________________________

Have there been any of the following major changes in the family during the last year?
___ change of address ___ accident or illness ___ divorce/marriage
___ parent separation ___ death of a family member ___ birth/adoption

Does anyone living in the home smoke? Yes No

Statement of the Problem

Describe in your own words the nature of your concerns about your child's development. ______________________

____

____

When did you first notice the problem? ____
What is your child's awareness of/reaction to this problem? __________________________________
How do you and other family members react to this problem? _________________________________
Has you child received any previous treatment for this problem? Yes No
Where? ____

What information do you hope to gain from this evaluation, and what specific questions or areas do you wish to address?

____

____

Prenatal and Birth History

Check any of the factors below that apply.
During Pregnancy

___ excessive vomiting
___ illnesses (i.e, German measles)
___ drug use
___ excessive weight loss/gain
___ premature rupture of membranes
___ hemorrhaging
___ medications
___ smoking
___ diabetes
___ x-ray treatments
___ Rh incompatibility
___ previous miscarriages
___ bed rest

Mother's general health during pregnancy: (illnesses, accidents, medications, etc…) __________________

____

____

Length of pregnancy: __________________________ Type of delivery: ____________________________
Birth weight: __________________________

Child's Medical History

List any major health conditions that your child has suffered including diseases, allergies, surgeries, and accidents. Please include approximate age of occurrence.

____

____

____

____

Check any of the illnesses/conditions that apply to your child:

___seasonal allergies
___ colds
___ dizziness
___ measles
___ Influenza
___ food allergies
___ seizures
___ ear infections
___ headaches
___ mastoiditis
___ asthma
___ croup
___ encephalitis
___ high fever
___ meningitis
___ mumps
___ pneumonia
___ sinusitis
___ tinnitus
___ tonsillitis
___ other ____

Has the child had any surgeries? If yes, what type and when (e.g. tonsillectomy, adenoidectomy, etc)? ___________
____
____

Describe any major accidents or hospitalizations. ____
____

Is your child taking any medications? If yes, identify. ____
____

Has your child had any injuries to the head? Did your child require any special attention or hospitalization due to a head injury? ____
____

Has your child ever used a pacifier or sucked on his/her thumb or fingers? Yes No How long? ____________

Hearing History

Do you suspect your child has a hearing problem? Yes No
If yes, what behaviors lead you to suspect this? ____
____

Do you question your child's ability to understand directions or conversations? Yes No
If yes, what behaviors lead you to suspect this? ____
____

What do you feel is the cause of the hearing problem? ____
____

How old was your child when you first suspected a problem with his/her hearing? ______________________

Has your child's hearing ever been tested? Yes No
Where: ____
When: ____
By Whom: ____
Results: ____
Recommendations: ____

Listening Habits (describe)
Ability to hear on the telephone: ______________________________ Ear used? _______________
Radio/MP-3/TV ____
Ability to hear one-on-one ____
Ability to understand in quiet ____
Ability to understand in noise ____
Ability to locate direction of sounds ____

Has your child ever worn: ___hearing aids ___FM system ____ No
Which ear? ____
Brand? ____
When was the hearing aid first fitted? __________________________________
How old is/are the aid(s)? ____
How long does your child wear hearing aid(s) every day?_______________________________________
Do you feel your child benefits from amplification? Yes No
Explain: ____
____

Speech and Language Development

Indicate when your child first demonstrated the following:

Age	Behavior	Age	Behavior
____	cooing, pleasure sounds	____	single words
____	babbling (ba-ba, da-da, etc.)	____	phrases (go bye-bye, more juice)
____	jargon (talking own special language)	____	short sentences

What is the primary method(s) your child uses for letting you know what he/she wants?

____ looking at objects ____ pointing at objects ____ gestures
____ crying ____ vocalizing/grunting ____ physical manipulation
____ single words ____ 2-3 word combinations ____ sentences

Which of the following best describes your child's speech?

____ easy to understand ____ difficult for parents to understand
____ difficult for others to understand ____ almost never understood by others
____ different from other children of the same age

Which of the following statements best describes your child's reaction to his/her speech?

____ is easily frustrated when not understood
____ does not seem aware of speech/communication problems
____ has been teased about her/his speech
____ tries to say sounds or words more clearly when asked
____ is successful in saying sounds or words more clearly when he/she tries

Is your child aware of his/her communication difficulties? Yes No
If yes, how does this awareness impact your child's social/emotional status? ________________________________
____
____

Does your child have difficulty producing certain sounds? Yes No
Which ones? ____
Does your child hesitate and/or repeat sounds or words? Yes No
Does your child "get stuck" when attempting to say a word? Yes No
Do you have concerns about your child's voice? Yes No
Which of the following do you think you child understands:

____ his/her own name ____ names of body parts ____ family names
____ names of objects ____ simple directions ____ complex directions
____ conversational speech

Motor Development

At approximately what age did you child achieve the following motor milestones?

____ head support ____ reach & grasp ____ sitting alone
____ crawling ____ standing alone ____ walking alone
____ climbing stairs ____ finger food ____ eat with a spoon
____ potty trained ____ undressed self

Is your child overly awkward or clumsy? Yes No
Does your child display a hand preference? Yes No Which hand? ________________________________
Has your child had any feeding difficulties? Check each item that applies.

____ sucking or nursing ____ reflux/vomiting
____ excessive length of time to drink bottle ____ allergies (formula/food)
____ difficulty chewing or swallowing meats ____ choking and/or gagging
____ regurgitation of liquids or solids through the nose

Does your child choke or cough while eating or drinking? Yes No
If yes, on what foods/drinks? ____
Is your child a picky eater? Yes No
If yes, what foods does he/she prefer? ____

Describe any feeding problems your baby experienced during the first three months of life. _______________
____

Does your child drool more than other children his/her age? Yes No
Did your child have difficulty gaining weight as an infant? Yes No
Explain: ____

Behaviors

Which of the following describes the type of play your child likes to engage in the most often?

____ putting toys in mouth
____ banging toys together
____throwing toys
____ appropriate use of objects
____ shaking toys
____pushing/pulling toys
____ uses one object for another
____ acting out familiar routines
____role-playing
____ make-believe play
____ games with rules
____ looking at books
____rough-and-tumble play

What is the average length of time your child can stay playing at one activity?_______________________
Which activities seem to hold your child's attention for the longest period of time? ___________________
____
Which activities seem to hold your child's attention for the shortest period of time? __________________
____
Is your child's play easily distracted by any of the following?
____ visual stimuli (i.e., other toys or objects)
____ auditory stimuli (i.e., voices, sounds outside, the TV)
____ nearby activities
____ other people in the room

Whom does your child prefer to play with (Please circle)
mother father brother/sister self other child other adult

List some of your child's favorite toys, activities, TV programs, and videos ___________________________
____
____

Social/Emotional Development

Check behaviors that you feel best describe your child. Check each item that applies.

____ overly active
____ defiant
____ overly quiet
____ excessive tantrums
____ nervous
____ easily controlled/passive
____ destructive
____ very shy
____ dependent upon routines
____ perfectionist
____ thumb sucking
____ difficulty separating from parent
____ friendly/outgoing
____ drooling
____ imaginative and creative
____ teeth grinding
____ mouth breather
____ plays well with other children
____ prefers older children
____ toileting issues
____ prefers younger children
____ interrupted/unusual eating habits
_____ interrupted/unusual sleeping habits

Describe any discipline problems you have with your child. ______________________________________
____
____

Has your child been seen by a psychologist, psychiatrist, counselor, or social worker for behavior or emotional problems?   Yes   No
Was a diagnosis given?____
Was medication recommended? ____
Is your child currently still seeing this professional? ____

Educational History

Educational Setting	Location/School	Teacher(s)
Child Care Facility		
Public/Private School Grade:		
Birth to 3 program		

How often does your child attend classes?
___ daily   ___ 2 times per week   ___ 3 times per week   ___ 4 times per week
___ ½ day   ___ full day

How many children are in your child's class?____
What type of classroom is your child attending? (i.e., traditional, open classroom, transdisciplinary, special education, etc.) ____
Does your child exhibit any learning style preferences?   visual   auditory   both
Have teachers expressed any concerns about your child's learning behavior?   Yes   No
If so, please describe. ____
____

Has your child ever been evaluated by:	Date	Location
____ speech pathologist	__________	______________________________
____ audiologist	__________	______________________________
____ vision specialist	__________	______________________________
____ occupational therapist	__________	______________________________
____ physical therapist	__________	______________________________
____ neurologist	__________	______________________________
____ child study team	__________	______________________________
____ psychologist	__________	______________________________
____ other	__________	______________________________

Is your child classified by the school district to receive special education and/or related services?   Yes   No

If yes, please explain ____
Date of classification ____________________ Type of classification _____________________
Date of last re-evaluation____
Type of services (self-contained class, resource room, in-class support) ___________________________
____

Please provide any additional information you feel may be helpful in evaluating your child. ____________
____
____
____
____

Thank you for your help. Your insights will enable us to provide the best evaluation for your child.

Please initial that you have received and read a copy of each of the following policies.

Financial Policy
I hereby acknowledge that I have received a copy of Baker Speech Clinic's Financial Policy.

Initials: _______________

Attendance and Inclement Weather Policies
I hereby acknowledge that I have received a copy of and understand Baker Speech Clinic's Attendance and Inclement Weather Policies.

Initials: _______________

HIPPAA/Notice of Privacy Practices
I hereby acknowledge that I have received a copy of Baker Speech Clinic's HIPPAA/Notice of Privacy Practices.

Initials: _______________

Video/Photo Release
I give consent for my child to be videotaped or photographed during a speech and language therapy session by Baker Speech Clinic for the purpose of assisting in formulating treatment plans or objectives, assisting in professional education, teaching or data collection.

Initials: _______________

Assignment of Benefits

I, ____, (Legal Representative) authorize speech-language evaluation/therapy by Baker Speech Clinic for ____. I understand that I am responsible for all charges incurred, regardless of insurance status. I agree to pay for services as they are provided and/or pay promptly upon receipt of a statement.

I acknowledge that the information I provided is accurate. I authorize my insurance company to pay Baker Consulting Services Group, LLC dba Baker Speech Clinic for services filed on my behalf. This assignment will remain in effect until revoked by me in writing. I authorize release of information necessary to secure payment from my insurance.

Printed name of person completing form: ____

Relationship to child: ____

Signature: ____ Date: _______________________