Chatting Children Speech and Language Center, LLC
22920 Bollinger Terrace
Brambleton, VA 20148
Phone: (202) 486-1411
Email: chattingchildren@gmail.com
Website: www.chattingchildren.com

Child's Name: _____ Date of Birth:_____ Today's Date: _____

Address: _____

Phone: _____
(home) (work) (cell)

Mother's Name: _____ Father's Name: _____

Mother's Occupation: _____ Father's Occupation: _____

Mother's email address: _____ Father's email address: _____

Name, Phone, Email of Nanny/Caregiver: _____

Siblings (include names and ages): _____

Referred by: _____

Pediatrician: _____ Phone: _____

Pediatrician's Address: _____

List other professionals working with (or who have worked with) your child:

Names/Professions: *Phone Numbers:*

_____

_____

_____

Is your child currently being treated by another speech-language pathologist? If so, please provide their name, telephone number and email.

_____

Does your child attend school, day-care or any other program? If so, please specify the name of program, days attended and length of day.

_____

Medical History

How was the mother's general health during pregnancy (please explain)? _____

_____

Were there any complications during labor and/or delivery (please explain)? _____

_____

Was your child born premature? If so, please provide details as to difficulties and treatment.

_____

Apgar scores: _____ Birth weight: _____

Was your child nursed and if so, for how long? _____

Was there anything remarkable about your child's early feeding history? _____

Has your child been given a medical diagnosis? ___ If yes, what diagnosis? _____

Has your child had any surgeries? ___ If yes, what type and when? _____

Has your child ever suffered from ear infections? ___ If yes, how many? ___ Which ears? _____

At what ages? _____ Were PE tubes inserted? _____ If yes, at what age? _____

Has your child's hearing been tested? ____ If yes, please indicate when, where and the results.

_____

Is your child sensitive to certain sounds/pitches (e.g., vacuum cleaners, blenders)? _____

Does your child cover his/her ears when he/she hears certain sounds? (specify) _____

Does your child seem under-reactive to loud sounds (e.g., fire trucks)? _____

Is your child currently taking any medications? ___ If yes, please identify. _____

Does your child have any allergies? If yes, please identify. _____

Is your child on a special diet? If yes, please describe. _____

Have any family members been treated by a speech-language pathologist? ____ Please explain.

_____

Have any family members been diagnosed with autism? _____

Developmental History

Please provide the approximate age at which your child began doing the following activities:

Crawl _____ Walk _____ Feed self _____ Use toilet _____

Use single words (e.g., mama, no, plane)_____

Combine words (e.g., daddy car, eat cookie) _____

Engage in conversation _____

What languages are spoken in the home or any of your child's other settings? _____

Do **you** understand your child when he/she communicates? _____

Do **others** understand your child when he/she communicates? _____

Is your child showing signs of frustration arising from his/her communication? _____

Does your child repeat sounds, syllables or words within an utterance (e.g., "b-b-b-ball")? _____

How often does your child repeat sounds, syllables or words? _____

Does your child make eye contact with others? _____

How does your child interact with other children and adults (e.g., shy, aggressive, uncooperative)?

_____

Please explain your child's typical eating habits: _____

_____

When eating, does your child prefer specific textures (e.g., mushy, crunchy), tastes (e.g., sour, sweet, salty), or temperatures (e.g., hot, cold)? _____

Does your child use an open cup? _____ Sippy cup? _____ Straws? _____

Does your child use a pacifier? _____ At what age did he/she stop? _____

Does your child suck his/her thumb? _____ At what age did he/she stop? _____

Does your child drool? _____

Can your child blow bubbles? _____ Party horns/whistles? _____

Describe your child's sleeping patterns. _____

Describe your child's activity level (low, typical, high). _____

Does your child exhibit any unusual behaviors or have unusual interests? If yes, please describe.

_____

What activities does your child enjoy the most? _____

How does your child spend most of his/her time? _____

How much time does your child spend watching TV per day? _____

How is your child doing academically (or pre-academically)? _____

_____

If enrolled for special education services, has an Individualized Education Plan (IEP) or other specialized plan been developed? If yes, what services are included? Please provide a copy of the IEP or plan.

_____

Which of the following concerns do you have? (check all that apply)

_____ 1) your child's overall articulation (pronunciation of words)
_____ 2) your child's comprehension of language
_____ 3) your child's ability to use language to converse
_____ 4) your child's eating habits
_____ 5) your child's dysfluent speech (stuttering)
_____ 6) your child's ability to read
_____ 7) your child's phonological awareness skills (pre-reading skills such as rhyming, sound ID)
_____ 8) your child's auditory processing
_____ 9) your child's play/social skills

Who recommended that you see a speech-language pathologist? _____

Please provide any additional information that might be helpful in the evaluation or remediation of your child's speech and language problem.

_____

_____

_____

_____

_____