NOLAN
Speech and Language Center

Personal Information

Patient's Name: _____ Date of Birth: ____/____/_____

Address: _____ City: _____ State: ____ Zip:_____

Cell Phone #: _____ Home Phone #: _____

Email: _____ Referred By: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Siblings (Names/Ages):

Educational Information

School District _____

Home School _____

Grade _____

Current Educational Program:
_☐_Regular _☐_ Special

Does your child have: _☐_IEP ☐504 Plan

What is your child's eligibility? *Circle*
SLI☐ LD☐ ASD☐ ECDD☐ EI☐ Other: ___

Services Received? *Circle*
PT☐ OT☐ Speech☐ Resource Room☐

Birth, Infant, & Child History

☐ Length of Pregnancy: _____ Duration of Labor: _____
☐ Type of Birth: _☐_Caesarian Birth _☐_Natural Birth
☐ Birth Weight: _____
☐ Birthing Complications, Describe:

☐ Mother's Health during pregnancy

☐ Difficulty Breathing, Describe:_____
☐ Breast Feed, Duration/Complications: _____
☐ Bottle Feed, Duration/Complications: _____
☐ Pacifier Use, Until What Age/Frequency: _____
☐ Thumb/Digit Sucking, Until What Age/Frequency:_____
☐ Frequent Colds/Weak Immune System, How Often:_____
☐ Ear Aches/Ear Infections, How Often:_____
☐ P.E. Tubes/Number of Times:_____
☐ Snoring:_____
☐ Adenoidectomy, Date/Results: _____
☐ Frequent Sore Throats/Tonsilitis/Strep:_____
☐ Tonsillectomy, Date/Results:_____
☐ Seasonal Allergies, Describe:_____
☐ Allergies/Intolerances to Foods, Describe: _____
☐ Head or Neck Surgeries: _____
☐ Abnormal Sleep Patterns: _____
☐ GERD/Acid Reflux, Treatment:_____
☐ Epilepsy: _____
☐ Did your child receive vaccinations? _____
☐ Are they up-to-date? _____
☐ Does your child have: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ G-Tube
☐ Dietary Restrictions: ☐ Kosher ☐ Vegetarian ☐ Gluten Free
☐ Casein Free ☐ Whole/Natural Foods
☐ Other: _____
☐ Was your child: _☐_quiet _☐_ babbled and cood?
☐ Does your child have difficulty: ☐ walking ☐ running ☐ throwing
☐ feeding ☐ other: _____

Developmental and Medical History

Please indicate the approximate age at which your child began to do the following:

Rolled over: _____
Sat unsupported:_____
Crawled:_____
Stood next to things: _____
Stood Alone: _____
Walked along furniture:_____
Walked: _____

Used Spoon: _____
Feed Self: _____
Drank from cup alone:_____
Dressed Self:_____
Toilet Trained:_____
Spoke Single words: _____
Spoke Phrases:_____
Used Crayons:_____

Please list any hearing or vision evaluations:

Evaluation/Therapy	Date	Where	By whom	Outcome

Has your child had any illnesses? If so, indicate severity, age, and side-effects.

Has your child ever been diagnosed by a physician, neurologist, or psychologist as having any type of neurological impairment or syndrome? _____ If yes, please explain:

Please list any evaluations or therapies that your child has had and their outcomes (i.e. speech, occupational, or physical therapy, neurological examination, MRI, etc.)

Evaluation/Therapy	Dates	Outcome

Does your child take any medications?

Medication	Amt/How Often (i.e. 15mg/2x day)	Condition (i.e. ADHD, Seizures)

Statement of Speech and Language Difficulty (Preschool Age)

My child has *DIFFICULTY*:

LISTENING

	Never	Sometimes	Frequently	Always
Understanding and following 1-2 step directions?	○	○	○	○
Understanding age-level vocabulary (e.g., nouns and verbs)	○	○	○	○
Responding appropriately to WH questions (e.g., who, what)	○	○	○	○
Responding appropriately to yes/no questions?	○	○	○	○
Responding appropriately to choice questions?	○	○	○	○
Responding to questions within expected time period?	○	○	○	○
Difficulty attending to what is said?	○	○	○	○
Ignoring distractions?	○	○	○	○
Understanding basic concepts (e.g., on, off, before, after)?	○	○	○	○
Listening to a complete story book?	○	○	○	○
Understanding new/novel ideas?	○	○	○	○

SPEAKING

	Never	Sometimes	Frequently	Always
Using age-appropriate sentences (e.g., 3-5 words per sentence)?	○	○	○	○
Using age-appropriate grammar skills (e.g., pronouns, articles)?	○	○	○	○
Asking questions?	○	○	○	○
Expressing daily needs (e.g., verbally or nonverbally)?	○	○	○	○
Using a variety of vocabulary words (e.g., 50-100 words)	○	○	○	○
Expressing likes and dislikes?	○	○	○	○
Retelling stories?	○	○	○	○
Sharing ideas?	○	○	○	○
Adding information?	○	○	○	○
Sequencing stories?	○	○	○	○
Asking for help when needed?	○	○	○	○

SOCIALIZING

	Never	Sometimes	Frequently	Always
Looking at people when talking or listening?	○	○	○	○
Providing nonverbal feedback (e.g., head nods, gestures)?	○	○	○	○
Maintaining conversation?	○	○	○	○
Understanding facial expressions, gestures, or body language?	○	○	○	○
Greeting people?	○	○	○	○
Using his/her own words?	○	○	○	○
Playing with other children?	○	○	○	○
Initiating conversation?	○	○	○	○
Interacting with others?	○	○	○	○
Following routines?	○	○	○	○
Coping with changes in routine?	○	○	○	○
Transitioning between activities?	○	○	○	○

BEHAVIOR

	Never	Sometimes	Frequently	Always
Is your child easily frustrated because of lack of communication skills?	○	○	○	○
Is your child having behavior difficulties in structured situations?	○	○	○	○
Is your child having behavior difficulties in unstructured situations?	○	○	○	○
Is your child aggressive with you or other children?	○	○	○	○

ARTICULATION

What are your concerns regarding your child's articulation skills? Check all that apply:

☐ Deletes sounds when speaking ☐ Changes sounds when speaking ☐ Distorts sounds when speaking

Is your child aware of his/her speech difficulty? ☐ Yes ☐ No

Does your child avoid speaking: ☐ Never ☐ Sometimes ☐ Always

Is it difficult to understand your child?: ☐ Never ☐ Sometimes ☐ Always

What percentage of your child's speech is intelligible to familiar listeners? ☐ % unfamiliar listeners? ☐ %

What does your child do if he/she is not understood by others? (e.g. points, takes you to object, etc.):

Child's Primary Language: _____

Language spoken in the home: _____

Describe in your own words what problem your child is having with speech, language, and/or hearing:

When did your child's speech and language skills first become an area of concern? _

Have any of your child's relatives had speech and language difficulties? If so, who and what type of difficulty did they have?

How does your child typically communicate (e.g., gestures, single words, screaming, phrases, sentences)?

Does your child try to make himself/herself understood? ☐ Yes ☐ No

If yes, please describe:

I affirm that the information I provided is correct to the best of my knowledge.

_____ _____

Signature - (Please Circle) Patient/Parent/Legal Guardian **Date**