



aim2achieve  
speech therapy

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender/Sex: \_\_\_ Male \_\_\_ Female

Child resides with: \_\_\_ Both Parents \_\_\_ Mother \_\_\_ Father \_\_\_ Other

Parent's email address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work #: \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Father's Address: \_\_\_\_\_

(if different than patient's)

**BILLING GUARANTOR (HOLDER OF INSURANCE)**

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Primary Ins. Company: \_\_\_\_\_

PLEASE SIGN: I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefit to **aim2achieve speech therapy** or myself if fee has not been paid. I understand I am financially responsible for my balance not covered by my insurance carrier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits or the benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Referred by \_\_\_\_\_

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# Pediatric Speech History

Patient's Name: \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Pediatrician's Name \_\_\_\_\_ Phone: \_\_\_\_\_

Pediatrician's Address \_\_\_\_\_

Please send a report to my pediatrician      Yes      No

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## Family History

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
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Is any language other than English spoken in the home?      YES      NO

If "yes" please explain \_\_\_\_\_

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

Length of pregnancy: \_\_\_\_\_ Length of Labor: \_\_\_\_\_

General Condition: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Circle type of delivery headfirst    feet first    breech    caesarean

Was there any unusual condition that may have affected the pregnancy or birth:      YES      NO

If "yes", please explain \_\_\_\_\_

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## Social History

Does your child interact well with others his/her own age? \_\_\_\_\_

Behavior problems? \_\_\_\_\_

School Grade \_\_\_\_\_ School Progress \_\_\_\_\_

School your child is presently attending: \_\_\_\_\_

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# Hearing History

Do you suspect your child has a hearing problem? YES NO

If "yes" what behaviors lead you to this? \_\_\_\_\_

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Has any member of our family, or your child's teacher, every expressed concern about your child's hearing?

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Does your child have a permanent hearing loss that you are aware of? (*For example: loss in one ear only, can't hear high pitch sounds*) \_\_\_\_\_

Do you question your child's ability to understand directions or conversations? YES NO

If yes, what behaviors lead you to suspect this? \_\_\_\_\_

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## Speech & Hearing History

(Provide approximate age of acquisition)

Coo and gurgle \_\_\_\_\_

Babbling \_\_\_\_\_

First word \_\_\_\_\_

Name objects \_\_\_\_\_

Combine 2-words \_\_\_\_\_

Was he/she a vocally "quiet" baby? \_\_\_\_\_

Did you hear a variety of sounds before his first words \_\_\_\_\_?

Give examples of his first words \_\_\_\_\_

Did/does your child prefer to point or use gestures? \_\_\_\_\_

Make short sentences \_\_\_\_\_

How would you describe your child's speech and or language problem?

\_\_\_\_\_  
\_\_\_\_\_

When did you first have concerns about his/her communication development?

\_\_\_\_\_  
\_\_\_\_\_

Does he/she have problems in understanding \_\_\_\_\_, expression \_\_\_\_\_, both \_\_\_\_\_?

Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do others have difficulty understanding your child? YES NO

What have you tried to do to help? \_\_\_\_\_

Has it improved his/her ability to communicate? \_\_\_\_\_

Are there any factors that may be limiting your child's development? (attention span, behavior, illnesses, hospitalizations, etc?) \_\_\_\_\_

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## Previous Interventions

Has there been any prior interventions for your child's speech and language issue?

For example: in-school therapy, prior private therapy, etc. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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# Developmental History

(Provide approximate age of acquisition)

At what age did your child walk? \_\_\_\_\_

At what age did your child say his first word? \_\_\_\_\_

Hold head up w/o support \_\_\_\_\_ eat cereals & pureed foods \_\_\_\_\_ night control \_\_\_\_\_

Roll Over \_\_\_\_\_ eat junior foods \_\_\_\_\_ dress w/o help \_\_\_\_\_

Sit up w/o support \_\_\_\_\_ self-feed with finger foods \_\_\_\_\_ color w/in outline \_\_\_\_\_

Crawl \_\_\_\_\_ drink from a cup \_\_\_\_\_ tie shoelaces \_\_\_\_\_

Stand alone \_\_\_\_\_ bladder control \_\_\_\_\_ use scissors \_\_\_\_\_

Walk alone \_\_\_\_\_

Describe any past or present feeding or sleeping problems: \_\_\_\_\_

Is he/she left or right handed? \_\_\_\_\_ Describe his/her motor skills? \_\_\_\_\_

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## General Development

Describe your child's general disposition: \_\_\_\_\_

Is he/she consistent from day to day? \_\_\_\_\_

Is/was your child ever over-sensitive to touch, sound, etc? \_\_\_\_\_

Does your child enjoy play with other children? \_\_\_\_\_

Describe child's general behavior: (shy, aggressive, hyperactive, kind, etc) \_\_\_\_\_

Discipline used in home? \_\_\_\_\_

Does discipline work with your child? \_\_\_\_\_

Your child's favorite activities, playmates, TV shows, etc. \_\_\_\_\_

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## General Health

General health of the child \_\_\_\_\_

High Fevers/Serious illnesses \_\_\_\_\_

Seizures/convulsions \_\_\_\_\_

Has the child had any surgeries? If yes, what type and when (e.g. tonsillectomy, adenoidectomy, and /or myringotomy with or without insertion of tympanostomy tubes etc.)?

Describe any major accidents or hospitalizations \_\_\_\_\_

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# Private Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

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## Release of Information

Patient's Name: \_\_\_\_\_

I hereby authorize **aim2achieve speech therapy** to discuss, release & receive my medical information to the following:

PHYSICIAN  
NAME: \_\_\_\_\_

PHYSICIAN  
NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ OTHER (PLEASE SPECIFY, NAME, ADDRESS, PHONE,)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
RELATIONSHIP