



PATIENT REGISTRATION FORM

Date Completed: _____

Identifying and Family Information

Child's Name: _____

Date of Birth: _____ Sex: M F

Age: _____

Parent's Name: _____

Parent's Name: _____

Home Phone: _____

Home Phone: _____

Cell Phone: _____

Cell Phone: _____

Work Phone: _____

Work Phone: _____

Address: _____

Address: _____

E-mail: _____

Email: _____

Child's Physician

Doctor's Name: _____

Practice: _____

Doctor's Phone: _____

Doctor's Fax: _____

Child Lives with (check one):

One Parent Foster Parents Birth Parents

Other Parent and Step-Parent Adoptive Parents _____

Other Children in the Family:

Name	Age	Sex	Grade	Presence of Speech/Hearing/Learning Problems

Is there a language other than English spoken in the home? Yes No

If yes, what language? _____

Does the child speak the language? Yes No

Does the child understand the language? Yes No

Who else speaks the language? _____

Which language does the child prefer to speak at home? _____

What are the child's interests? What does he/she enjoy? _____

Birth and Medical History

Was there anything unusual about the pregnancy or birth? Yes No

If yes, please describe. _____

How old was the mother when the child was born? _____

Was the mother ill during the pregnancy? Yes No

If yes, please describe. _____

How many weeks was the pregnancy? _____

Did the child go home with his/her mother from the hospital? Yes No

If the child stayed at the hospital, please describe reason and length of stay.

Has your child had any of the following?

- Adenoidectomy
- Allergies
- Breathing Difficulties
- Chicken Pox
- Colds
- Ear Infections
- Mumps
- Scarlet Fever
- Encephalitis
- Flu
- Head Injury
- High Fevers
- Meningitis
- Tonsillitis
- Vision Problems
- Seizures
- Sinusitis
- Sleeping Difficulties
- Thumb/Finger Sucking Habit
- Tonsillectomy
- Ear Tubes

Other serious injury/surgery: _____

Has your child been diagnosed with any of the following?

- Attention Deficit Disorder
- Sensory Integration Disorder
- Autism Spectrum Disorder
- Down Syndrome
- Intellectual Disability
- Pervasive Developmental Disorder
- Other _____
- Auditory Processing Disorder
- Attention Deficit Disorder with Hyperactivity
- Specific Learning Disability - Reading, Written Expression, and/or Math
- Epilepsy
- Stroke
- Behavior or Emotional Disorder

Is your child currently (or recently) under a physician's care? Yes No

If yes, why? _____

Please list any medications your child takes regularly:

Are there any precautions that should be taken with the child?

Please describe any pertinent family medical history (i.e. mother, father, siblings, and grandparents):

Please give the approximate age your child achieved the following developmental milestones:

- _____ Babbled
- _____ Used single words meaningfully
- _____ Began combining words
- _____ Spoke in short sentences
- _____ Toilet trained
- _____ Sat alone
- _____ Walked
- _____ Grasped crayon/pencil

**Does your child...
(Check all that apply)**

- choke on food or liquids?
- currently put toys/objects in his/her mouth?
- brush his/her teeth and/or allow brushing?
- Is your child a picky eater?

Does your child...

(Check all that apply)

- repeat sounds, words or phrases over and over?
- understand what you are saying?
- retrieve/point to common objects upon request (ball, cup, shoe)?
- follow simple directions (“Shut the door” or “Get your shoes”)?
- respond correctly to yes/no questions?
- respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

(Check all that apply)

- body language (pointing, looking, gesturing)
- sounds (vowels, grunting)
- words (shoe, doggy, up)
- two- to four-word sentences
- sentences longer than four words
- other _____

Behavioral Characteristics:

Your child is/demonstrates:

(Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> cooperative | <input type="checkbox"/> restless |
| <input type="checkbox"/> attentive | <input type="checkbox"/> poor eye contact |
| <input type="checkbox"/> willing to try new activities | <input type="checkbox"/> stubborn |
| <input type="checkbox"/> easily distracted/short attention | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> plays alone for reasonable length of time | <input type="checkbox"/> self-abusive behavior |
| <input type="checkbox"/> destructive/aggressive | <input type="checkbox"/> separation difficulties |
| <input type="checkbox"/> easily frustrated/impulsive | <input type="checkbox"/> inappropriate behavior |

Do you feel the child has a speech and/or language problem? Yes No

If yes, please describe. _____

Do you feel the child has a hearing problem? Yes No

If yes, please describe. _____

Has he/she ever had a speech evaluation/screening? Yes No

If yes, where and when? _____

What were the results? _____

Has he/she ever had a hearing evaluation/screening? Yes No

If yes, where and when? _____

What were the results? _____

Has the child ever had speech therapy? Yes No

If yes, where and when? _____

What was he/she receiving therapy for? _____

Has the child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? Yes No

If yes, please describe. _____

Is your child aware of, or frustrated by, any speech/language difficulties?

What do you see as your child's most difficult problem in the home?

What do you see as your child's most difficult problem in school?

If the child is in school, please answer the following:

Name of school: _____

Grade: _____

Teacher's name: _____

Has the child repeated a grade?

What are the child's strengths and/or best subjects?

Is the child having difficulty with any subjects?

Is the child receiving help in any subjects?

Please add any other information that may be useful in treating your child.

