ClearlySpeaking therapy

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:

Birth Parent(s) ○ Adoptive Parents ○ Foster Parents ○
Parent and Stepparent ○ Other ○

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

Other serious injury/surgery:

_____

_____

Has your child been diagnosed with any of the following?

Attention Deficit Disorder	Auditory Processing Disorder
Sensory Integration Disorder	Attention Deficit Disorder with Hyperactivity
Autism Spectrum Disorder	Specific Learning Disability - Reading, Written Expression, and/or Math
Down Syndrome	Epilepsy
Intellectual Disability	Stroke
Other _____	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	_____ Toilet trained
_____ Used single words meaningfully	_____ Sat alone
_____ Began combining words	_____ Walked
_____ Spoke in short sentences	_____ Grasped crayon/pencil

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

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

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:
(Check all that apply)

cooperative
attentive
willing to try new activities
easily distracted/short attention
plays alone for reasonable length of time
destructive/aggressive
easily frustrated/impulsive
restless
poor eye contact
stubborn
withdrawn
self-abusive behavior
separation difficulties
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.
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____