All of Me Therapy, LLC

Date: _____

CHILD/FAMILY HISTORY

Child's Name _____ Birthdate ___/___/___ Age _____ Sex ☐M ☐F Grade _____

Primary language(s) in the home _____ Child's primary language _____

Name and relationship of person completing questionnaire _____

REFERRAL INFORMATION

Referred by (family, physician, clinic, other professional etc.) _____

What are your main concerns regarding your child's communication skills?

_____

_____

What do you hope to gain from this evaluation?

_____

_____

RESPONSIBLE PARTY

Responsible party and relationship to child _____

Address _____

Cell Phone (_____) _____-_____ Accept text messages? □ Y □ N Home Phone (_____) _____-_____

Work Phone (_____) _____-_____ Email _____

I give consent for All of Me Therapy, LLC to communicate with me and my therapy providers through non-secured electronic correspondence (email & texting). I acknowledge and agree that information sent via email is not considered secure. Therefore, I agree that All of Me Therapy, LLC has no liability to me for any loss, claim, or damages arising or in any way related to response(s) to any email or other electronic communication.

Parent/Guardian Signature: _____ Date: _____

FAMILY INFORMATION

Parent's marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Deceased ☐ Other

Please list all family members who spend a significant amount of time with the child:

Name (parent's, stepparents, siblings, grandparents, etc.)	Age	Occupation	Health Concerns	Sex M/F	Lives in the home?

Any other caregivers? _____

What are the child's favorite activities and/or games? _____

_____

DEVELOPMENTAL HISTORY

Prenatal

□ Excessive vomiting □ Excessive fatigue □ Premature labor □ Excessive weight gain □ Inadequate weight gain

□ Anemia □ Heart problems □ Rh incompatibility □ High Blood Pressure

□ Medications other than prenatal vitamins □ Special Diet □ Thyroid Disease □ Diarrhea

□ Diabetes □ Swelling □ Fever □ Preeclampsia □ Bleeding/spotting

□ Measles □ Accident □ Bedrest □Premature rupture of membranes

□ Exposure to smoke □ Exposure to drugs □ Exposure to alcohol □ Exposure to domestic violence

Comments: _____

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Labor and Delivery

Gestational Age? _____ ☐ Vaginal Delivery ☐ C-Section Birth Weight? _____ Birth Length? _____
☐ Regular Nursery ☐NICU Length of stay? _____ Reason for extended stay? _____
_____
Any complications during or after delivery? _____
_____

Infancy/Childhood

Please describe in detail the first two years of the child's life. Was s/he fussy, happy, colicky, etc.? Any outstanding events? Was the child exposed to any toxins? _____
_____
_____
_____
_____
Any reactions to immunizations? _____
Breastfed ☐Y ☐N How long? _____ Thumb sucking or pacifier use? ☐Y ☐N How long? _____
Toilet trained? ☐Y ☐N Age? _____ Health concerns? ☐Y ☐N Explain _____

Milestones

My child was (check all that apply): ☐ alert ☐ easily comforted ☐ colicky ☐ aware of light/sound ☐ difficult to comfort ☐ lethargic
My child's early motor development (walking, talking toileting, etc.) was: ☐ early ☐ average ☐ late
Please indicate when each milestone was met:
Sat up unassisted _____ Crawled _____ First word _____
2-3 word phrases _____ Walked unassisted _____ Full sentences _____
Did the child babble and coo? _____ Was the child a quiet baby? _____

Health

Physician (name, address, phone number) _____
_____ Date of last visit? _____
How would you describe the child's current general health? _____
Is there a history of any of the following?

	Yes	No	Comments
Allergies			
Asthma			
Autism/PDD			
Bronchitis			
Seizures/Epilepsy			
Ear Infections			
Gastrointestinal Problems			
Serious Injuries			
Surgeries			
Hospitalizations			
Sensory Integration Issues			
Feeding Problems			

Is the child currently taking any medications? _____ For what? _____
Any allergies? _____ Is the child following a particular diet? _____

Visual Development

Date of last eye exam? _____ Results? _____
Does the child wear glasses? ☐Y ☐N Is the child sensitive to light? ☐Y ☐N Does the child squint? ☐Y ☐N
Any other concerns with the child's vision? _____
_____

Auditory Development

Date of last hearing screening? _____ Results? _____
Chronic of ear infections? _____ How many? _____ PE Tubes? _____ How long? _____

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Does the child have a diagnosis of hearing loss? _____ Correction? _____

Does your child:

☐ Y ☐ N Hear things before you hear them?
☐ Y ☐ N Seem overly sensitive to sound?
☐ Y ☐ N Become frightened by certain sounds? What sounds? _____
☐ Y ☐ N Miss some sounds?
☐ Y ☐ N Seem confused about the direction of sounds?
☐ Y ☐ N Like to make loud noises?
☐ Y ☐ N Become easily distracted?
☐ Y ☐ N Tend to 'tune you out' when there is background noise present, such as a fan, dishwasher, or tv?
☐ Y ☐ N Need to have instructions repeated frequently?
☐ Y ☐ N Often say, "What?" or "Huh?"
☐ Y ☐ N Often fail to pay attention when being spoken to?
☐ Y ☐ N Often need an unusually long amount of time to process verbal information before responding?
☐ Y ☐ N Often have difficulty remembering what was said?
☐ Y ☐ N Frequently lose his/her concentration?
☐ Y ☐ N Have others who work with the child (i.e., teacher, therapist) commented on his/her listening skills?

Speech and Language Development

Is the child talking yet? ☐ Y ☐ N

Describe the child's speech and language and any problems _____

_____

Does the child have difficulty pronouncing certain sounds? _____ If so, please list _____

Does the child mumble often? _____ Does the child seem inhibited by his/her speech difficulty? _____

Does the child often reduce or transpose the number of syllables in a word? (ex" "Indiana" pronounced as "danna") _____

If school age, does the child write words with the same error pattern exhibited in their speech? _____

What percentage of the child's speech can the mother understand? All Most Some Very Little

What percentage of the child's speech can other adults understand? All Most Some Very Little

Expressive Language

☐ Y ☐ N Does the child use a lot of gestures?
☐ Y ☐ N Does the child seem frustrated by his/her difficulty talking?
☐ Y ☐ N Does the child nod his/her head for yes/no questions?
☐ Y ☐ N Does the child repeat (echo_ the question instead of answering it?
☐ Y ☐ N Does the child seem disinterested in talking?
☐ Y ☐ N Does the child seem overly interested in one particular thing?
☐ Y ☐ N Does the child seem to be exceptionally good at learning letters or reading?
☐ Y ☐ N Does the child seem to be exceptionally good at doing puzzles?
☐ Y ☐ N Does the child seem to be exceptionally good with, or interested in, computers?
☐ Y ☐ N Does the child seem to 'ramble on' (out of sequence) when retelling events or explaining so that it is difficult to follow?
☐ Y ☐ N Does the child use an inordinate amount of "uhs" and "ums" in his/her conversational speech?
☐ Y ☐ N Does the child use vague language frequently, so that it is difficult to follow at times?
☐ Y ☐ N Does the child tend to confuse positional words, such as "left/right"?
☐ Y ☐ N Does the child have difficulty speaking in complete sentences with normal grammar?
☐ Y ☐ N Does the child have a difficult time elaborating on a topic; yet can answer Y/N questions about it?
☐ Y ☐ N Does the child forget names of familiar things?
☐ Y ☐ N Does the child have trouble answering "wh" questions?

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Motor Development

Hand Dominance: R L Age Established? _____

Does the child:

Muscle Tone

□ Y □ N Have a grasp that is less mature than peers/

□ Y □ N Seem weaker or stronger than normal? Explain: _____

□ Y □ N Have any diagnosed muscle pathology? (e.g., spasticity, flaccidity, rigidity) Explain: _____

Coordination

□ Y □ N Have difficulty manipulating small objects easily

□ Y □ N Seem accident prone?

□ Y □ N Eat in a sloppy manner?

□ Y □ N Have difficulty dressing and/or fastening clothes? Explain: _____

□ Y □ N Have a consistent hand dominance?

□ Y □ N Have trouble riding a tricycle and/or bicycle?

□ Y □ N Have trouble playing on playground equipment?

Sensory – Tactile Sensation

□ Y □ N Object to being touched/cuddled? Explain: _____

□ Y □ N React negatively to the feel of new clothes?

□ Y □ N Prefer certain textures of clothing?

□ Y □ N Dislike having hair and/or face washed? Explain: _____

□ Y □ N Dislike having teeth brushed and/or nails clipped? Explain: _____

□ Y □ N Avoid certain textures of food? Explain: _____

□ Y □ N Isolate self from other children? Explain: _____

Sensory – Vestibular Sensation

□ Y □ N Seem fearful in space (i.e., going up and down stairs)? Explain: _____

□ Y □ N Appear clumsy, often bumps into thing or falls down? Explain: _____

□ Y □ N Climbs well but is cautious of others bumping into him/her? Explain: _____

□ Y □ N Spins?

□ Y □ N Walk upstairs always leading with the same foot?

Sensory – Olfactory

□ Y □ N Explore the environment with smell? Explain: _____

□ Y □ N Discriminate odors poorly?

□ Y □ N React defensively to smell" Explain: _____

Sensory – Gustatory Sensation

□ Y □ N Acts as though all food tastes the same? Explain: _____

□ Y □ N Open to tasting new foods?

□ Y □ N Dislike foods of a certain texture or multiple textures? Explain: _____

□ Y □ N Avoid or crave certain temperatures of food? Explain: _____

Oral Motor Development

How would you describe the child's chewing and swallowing? (check all that apply)

□ Typical for his/her age

□ Messy for his/her age

□ Chokes at times, more than I would expect

□ Has a limited number of foods s/he will eat (list favorites _____)

□ Avoids hard and crunchy foods

□ Stuffs lots of food into his/her mouth

□ Drools when at rest

□ Drools when eating

□ Liquids leak from nose

Are you concerned with the child's nutrition as a result of his/her feeding difficulties? Describe: _____

_____

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Social Interactions and Behavior (check all that apply)

How would you describe the child's social interactions? ☐Typical for age ☐Quiet ☐Outgoing

☐ Likes to point out things to show you
☐ Does not play 'pretend' or imaginary games well
☐ Usually doesn't acknowledge people (waving, saying 'hi') when they enter unless prompted
☐ Usually doesn't acknowledge people (waving, saying 'bye') when they leave unless prompted
☐ Is unusually active for his/her age
☐ Prefers playing alone
☐ Prefers to play with younger children
☐ Has a shorter attention span than would be expected for his/her age
☐ Avoids eye contact
☐ Doesn't seem to know *how* to interact with other children even though s/he wants to
☐ Is unusually irritable on noisy or crowded places such as malls, parties, etc.
☐ Often repeats phrases heard out of context
☐ Doesn't respond to his/her name consistently
☐ Has periodic screaming fits (beyond typical tantrums)
☐ Short temper
☐ Can be violent or unusually physically aggressive (beyond typical childhood outbursts)

Any other behavior or emotional concerns? _____

PREVIOUS EVALUATIONS AND TREATMENT

Is there a family history of speech, language, or learning disabilities? _____ If yes, please explain _____

_____

Has your child been diagnosed with Autism Spectrum Disorder? _____ Age at diagnosis? _____ Who diagnosed? _____

Has your child previously been diagnosed with any condition that would affect his/her speech, language, or auditory skills? (Down Syndrome, PDD, Cerebral Palsy, Hearing Impairment, etc.) _____

Has the child been evaluated for speech, language, or auditory problems in the past? _____ When? _____

Results? _____

Has the child been evaluated by a physical or occupational therapist in the past? _____ When? _____

Results? _____

Has the child been evaluated by a psychologist or learning specialist in the past? _____ When? _____

Results? _____

Has the child been evaluated by a neurologist in the past? _____ When? _____ Results? _____

_____

Has the child been evaluated by and ear-nose-throat physician? _____ When? _____ Results? _____

_____

EDUCATIONAL HISTORY

Did the child attend preschool? ☐Y ☐N Ages? _____ Where? _____

Has the child ever repeated a grade? ☐Y ☐N Which grade? _____

Has the child ever participated in a special education evaluation? ☐Y ☐N When? _____

Has the school system implemented an IEP for the child? ☐Y ☐N Date: _____ School? _____

School Problems

If the child is currently attending school, please check off each area the child is having difficulty in:

☐ learning the names of letters
☐ printing letters
☐ spacing words and letters on the page
☐ remembering the sounds the letters make
☐ putting letters together to sound out a word
☐ comprehending information that has been read
☐ following directions from the teacher
☐ spelling
☐ writing spelling words in sentences

□ keeping his/her attention on the teacher
□ completing homework independently
□ gripping the pencil without breaking the tip or his/her hand getting sore
□ copying letters or words from the board to his/her paper
□ copying anything from a book or paper to another paper
□ forgetting assignments/books at school
□ learning math facts
□ understanding math word problems
□ learning and remembering vocabulary for subjects such as Social Studies
□ pronouncing and learning new multi-syllabic words
□ remembering what people say
□ putting things in order (sequencing, days of the week, months of the year, etc.)
□ misunderstanding what to do on assignments or projects
□ taking tests orally
□ answering fill in the blank questions
□ answering open ended essay questions

Additional parent observations/comments regarding academic achievement: _____
_____
_____
_____

BEHAVIOR/CHARACTER

Please describe any behaviors that are a concern at home, at school, or in the community. What was the age of onset and the age you became concerned? _____
_____
_____
_____

List:

Strengths	Weaknesses

Check any behavior characteristics that apply to the child:

	Aggression		Low self-esteem		Short attention span
	Unusual Fears		Manipulative		Sleep problems
	Depression		Nail biting		Frequent crying
	Impulsive		Nightmares		Truancy
	Noncompliant		Perfectionist		Moodiness
	Substance Abuse		Tics/nervous gestures		Hyperactivity/Attention Deficit Disorder
	Poor motivation/apathy		Bedwetting/toileting problems		Unkempt personal appearance

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Please check all areas of concern:

	Attention		Focusing
	Following Directions		Understanding what is being said
	Behavior		Speech
	Language		Tantrums
	Motor Skills		Reading and Spelling
	Learning		Social Skills
	Transitions and Flexibility		Sleep Patterns
	Food Habits		Other (describe)

Please check all areas you would like to see improvement:

	Listening		Learning
	Attention		Speaking
	Behavior		Critical Thinking
	Reading and Spelling		Organization
	Social and Behavioral Skills		Memory
	Motor Skills		Other (describe)

Describe the child's typical day: _____
_____
_____
_____

Describe the child's interests and activities: _____
_____
_____
_____

Is there any additional information that would help us better understand the child? _____
_____
_____
_____
_____

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