Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

PS3597

Child's Name: _____ Date of Birth: _____
Mother's Name: _____ Father's Name: _____
Address where child lives: _____
Child lives with ❑ Mother & Father ❑ Mother ❑ Father ❑ Other _____
Telephone: (home) _____ (work) _____ (cell) _____
Reason for evaluation: _____
Referred by _____
Person completing form ❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Other - Name _____

Results will be sent to names/locations listed below if address or faxes are provided

Name, Address or Fax Phone

- _____
- _____
- _____

Disclosure of healthcare information will only be provided if authorized by the patient or legal guardian except for known healthcare providers.

_____
Name Relationship to patient Address/ phone/ fax

_____
Name Relationship to patient Address/ phone/ fax

I authorize the Speech-Language Pathology Department to disclose healthcare information to names above. Valid for one year.

Signature of ❑ Patient ❑ Parent/Guardian _____ Date _____
Printed Name of Parent/Guardian _____

Pregnancy History:

Length of pregnancy: _____weeks
Please describe any illness/hospitalization of mother during pregnancy: _____
_____

- Parent drug use before pregnancy: YES NO If yes, please explain: _____
- Alcoholic intake during pregnancy: YES NO If yes, list # per week: _____
- Mother drug use during pregnancy: YES NO If yes, please explain: _____
- Mother prescription drug use during pregnancy? YES NO If yes, please explain:

_____

Birth History:

Hospital Name/Location: _____
Delivery: ❑ Vaginal delivery ❑ Caesarean delivery; Why? _____
Was the child one of a multiple birth? _____ Birth Weight: _____
Was anesthesia/medication given? ❑ YES ❑ NO If yes, what kind? _____
Complications/Treatments: How Long _____
Breathing Problems? ❑ YES ❑ NO _____

Medical History:

Does the child have any of the following (past or present):

- ❑ YES ❑ NO ADD/ADHD
- ❑ YES ❑ NO Colds
- ❑ YES ❑ NO Allergies
- ❑ YES ❑ NO Gastric Reflux
- ❑ YES ❑ NO Diabetes
- ❑ YES ❑ NO Epilepsy
- ❑ YES ❑ NO Chicken Pox
- ❑ YES ❑ NO Hepatitis
- ❑ YES ❑ NO Heart Problems
- ❑ YES ❑ NO High Fevers
- ❑ YES ❑ NO Asthma
- ❑ YES ❑ NO Hearing Loss
- ❑ YES ❑ NO Cerebral Palsy
- ❑ YES ❑ NO Learning Disability
- ❑ YES ❑ NO Ear Infections
- ❑ YES ❑ NO Respiratory Disease
- ❑ YES ❑ NO Seizures
- ❑ YES ❑ NO Cancer
- ❑ YES ❑ NO Intellectual Disability

Please list any other medical history, surgeries and *medications* along with dosages:

_____

_____

❑ Allergies: _____

Family and Social History:

Has anyone in your family had? Relationship to child.

- ADD/ADHD ❑ YES ❑ NO _____
- Trouble speaking clearly ❑ YES ❑ NO _____
- Hearing impairment ❑ YES ❑ NO _____
- Learning disability ❑ YES ❑ NO _____
- Mental retardation ❑ YES ❑ NO _____
- Genetic disorder ❑ YES ❑ NO _____
- Cleft lip/ cleft palate ❑ YES ❑ NO _____
- Speech or language delay ❑ YES ❑ NO _____

Other: _____

Primary Language: ❑ English ❑ Spanish ❑ Other: _____

Does child speak a second language? (Please list) _____

What language does the child use most comfortably? _____

List any brother/sisters and ages? _____

Who lives in the home? _____

Marital status of parents? _____ Are there significant marital conflicts? ❑ YES ❑ NO

General Behaviors:

Does your child exhibit any of the following?

- Clumsiness ❑ YES ❑ NO
- Head banging ❑ YES ❑ NO
- Hitting ❑ YES ❑ NO
- Scratching ❑ YES ❑ NO
- Tantrums ❑ YES ❑ NO
- Biting ❑ YES ❑ NO
- Difficulty getting along with other children ❑ YES ❑ NO

Other: _____

If so, in response to what and how often? _____

_____

Any other information that you feel would be important for us to know? _____

_____

_____

_____ _____ _____

NYS licensed Speech-Language Pathologist's Signature **Date** **Time**

_____

(Print Name)