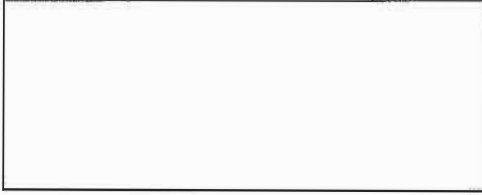


Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777



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