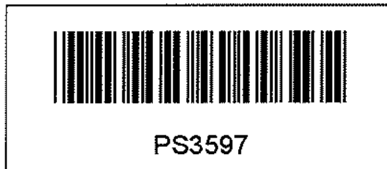
Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777



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

____
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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 ______________________

Transfusions? ❑ YES ❑ NO ______
Phototherapy? ❑ YES ❑ NO ______
Respirator Use? ❑ YES ❑ NO ______
Incubator Use? ❑ YES ❑ NO ______
Other: ______

Educational History:
Does your child attend school? ❑ YES ❑ NO Where? ______
How many days per week? ______ Half or full day? ______
Grade: ______ Teacher's Name: ______
Does your child have any problems at school? ______
Please describe any special tutoring/therapy: ______
Does your child have difficulty with attention, learning, reading, spelling, writing, math? ❑ NO ❑ YES
(please explain) ______

Developmental History: Motoric Development: The age achieved/further information.

- Head support: ❑ YES ❑ NO ______
- Unsupported sitting: ❑ YES ❑ NO ______
- Walking without holding on: ❑ YES ❑ NO ______
- Trained for bowel/bladder: ❑ YES ❑ NO ______
- Does he/she have urine or bowel control problems? ❑ YES ❑ NO ______
- Does child have difficulty sucking? ❑ YES ❑ NO ______
- Does child have difficulty chewing? ❑ YES ❑ NO ______
- Does child drool? ❑ YES ❑ NO ______
- Current diet: ❑ Regular solids ❑ Cut up foods ❑ Baby Foods stage ______ other ______

Therapy: Name/Location/Phone number of therapist: ______

- Does your child receive Physical Therapy: ❑ YES ❑ NO ______
- Does child receive Occupational Therapy: ❑ YES ❑ NO ______
- Does child receive Speech-Language Therapy: ❑ YES ❑ NO ______
- If yes, indicate frequency of therapy per week: ______, for ______ minute sessions

Speech - Language Development:
Age child began to babble: ______
Age child began to use meaningful words: ______
Age child began to combine two to three words: ______
Current communication: ❑ Verbal/sentences ❑ Verbal/few words ❑ Vocalizing ❑ Gesturing ASL
Does your child understand directions: ❑ 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)