



Twice Exceptional

Speech, Language & Educational Therapy

General Information Today's Date: ____/____/____

Child's Name: _____ Date of Birth: _____

Address: _____ Phone H C W: _____

City: _____ Zip: _____ Text Reminder: Y / N

School: _____ Grade: _____ District: _____

Teacher: _____ Email: _____

If P-K, please list days and times: _____

Does child live with both parents? _____

Other Address: _____ Relation: _____

What other languages are spoken at home? _____

Mother/Parent 1 Name: _____ H C W Phone: _____

Occupation: _____ C W Phone: _____

Father/Parent 2 Name: _____ H C W Phone: _____

Occupation: _____ C W Phone: _____

Email: _____ Text Reminder: Y / N

Referred By: _____ Phone: _____

Address: _____

Family Doctor: _____ Phone: _____

Address: _____

Insurance Provider: _____ Annual Benefits Start Date: ____/____/____

ID Number: _____ Group Number: _____

Claims Address (see reverse of card): _____

Brothers, Sisters and other important caregivers (include names and ages):



Twice Exceptional

Speech, Language & Educational Therapy

Communication History

With whom does the child spend the most of his or her time?

Describe the child's speech-language problem.

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed?

Is the child aware of the problem? Have you addressed it with the child? If yes, how does he or she feel about it?

Does the child experience frustration during moments of communication difficulty? If so, please describe in detail what this looks like (e.g. tantrum, chooses not to talk, screaming, behavior).

How does the child usually communicate? (gestures, single words, short phrases, sentences).



Twice Exceptional

Speech, Language & Educational Therapy

What do you think may have caused the problem?

Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions? **Please bring reports if containing pertinent information.**

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen your child? If yes, please indicate the type of specialist, when the child was seen and the specialist's conclusions or suggestions. **Please bring reports if containing pertinent information.**

Does your child have any conditions or oral abnormalities that may affect communication?

Are there any other speech, language or hearing problems in your family? If yes, please describe.

Is there a family history of reading, writing, spelling or learning challenges? If yes, please describe.



Twice Exceptional

Speech, Language & Educational Therapy

Prenatal and Birth History

Describe the mother's general health during pregnancy (illness, accidents, medications, etc.):

Length of pregnancy: _____ Length of labor: _____
General Condition: _____ Birth weight: _____
Circle type of delivery: head first feet first breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History

Provide the approximate age at which the child suffered the following illnesses and conditions:

Condition	Age	Condition	Age	Condition	Age
Asthma		Chicken Pox		Colds	
Croup		Dizziness		Draining Ear	
Ear Infections		Encephalitis		German Measles	
Headaches		High Fever		Influenza	
Mastoiditis		Measles		Meningitis	
Mumps		Pneumonia		Seizures	
Sinusitis		Tinnitus		Tonsillitis	
Allergies: Type(s) & Age(s)					
Other					

Has the child had any surgeries? If yes, what type and when (e.g. tonsillectomy, tube placement)?



Twice Exceptional

Speech, Language & Educational Therapy

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify drug type and dosage.

Does the child sleep through the night? If no, describe the pattern.

Is the child a picky eater? If yes, please describe.

Does the child have any positive or negative reactions to food, clothing or object texture? If so, please describe.

Developmental History

Are there or have there ever been any feeding problems (e.g. problems with sucking, swallowing, drooling, chewing)? If yes, please describe.

Does the child have difficulty walking, running or participating in other activities that require small or large muscle coordination?



Twice Exceptional

Speech, Language & Educational Therapy

Developmental Milestone	0-3 mo	3-6 mo	6-9 mo	9-12 mo	12-15 mo	15-18 mo	18-21 mo	21-24 mo	24-27 mo	27-30 mo
Crawled										
Stand Unaided										
Walked Unaided										
Fed Self with Spoon										
Babbled										
Moves Head Toward										
Spoke First Word										
Vocabulary of 25 Words										
Vocabulary of 100 Words										
Vocabulary of 300 Words										
Name Simple Objects										
Used Two Word										
Used Simple Sentences										
Followed 2-Step										
Conversed Easily										
Asked Simple Questions										
Dress Self										
Use Toilet										

Educational History

Do you have any concerns regarding the child's academic development at this time? If yes, please describe.

Does the child receive special services? Has an Individualized Educational Plan (IEP) been developed? If yes, describe and list school district.



Twice Exceptional

Speech, Language & Educational Therapy

Does the child show signs of preferential handedness?

Academic Skill	Never	Starting To	Sometimes	Always
Interested in books				
Child has desire for parent to read to them frequently				
Will look at books independently				
Recognizes print				
Recognizes specific letters				
Pairs letters with sounds				
Holds books with correct orientation				
Will flip from front to back				
Identifies picture and produces word				
Can grasp a writing utensil				
Experiments with writing				
Writes letters				

Social History

How does the child interact with adults, peers, family and unfamiliar people (e.g. shy, aggressive, uncooperative).

Describe a typical interaction with peers at a playground.
