General Information

Childs Full Name: _____ DOB: _____ Age: _____

Parent/Guardian(s) Name: _____

Primary Language(s) Spoken at Home: _____

Pediatrician Name: _____

Pediatric Office Name and Address: _____

Referral Source: _____

Primary Concerns

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

_____

At what age were concerns first had?

_____

Has your child received a formal diagnosis? (e.g., ASD, ADHD, Childhood Apraxia of Speech, GDD, etc)

_____

What are your primary goals for therapy?

_____

Signature of Parent/Guardian: _____ Date: _____

Medical and Birth History

- **How many weeks gestation was the child born? _____**
- **How much did the child weigh in pounds and ounces? lbs ozs**
- **How was the child delivered (cesarean or natural)? ◯ Cesarean ◯ Natural**
- **Please describe any concerns or complications during labor or delivery if applicable: _____**
- **Has your child had a recent hearing screening? ◯ Yes ◯ No**
- **Does your child have a history of chronic ear infections? ◯ Yes ◯ No**
- **Please list any chronic illnesses, surgeries, or hospitalizations:**

  _____
- **Please list any current medications:**

  _____

Developmental Milestones

At what age did your child do the following:

- **Sitting up:** Weeks Years
- **Crawling:** Weeks Years
- **Walking:** Weeks Years
- **First words:** Weeks Years
- **Combine two words:** Weeks Years
- **Feed self:** Weeks Years

Does your child have difficulty during feeding? (swallowing, chewing, food aversions, etc): _____

Signature of Parent/Guardian: _____ Date: _____

Current Communication Skills

What is your child's preferred method of communication? _____

Does your child follow one-step or two-step directions? ◯ Yes ◯ No

What percentage of your child's speech do you understand? _____

Does your child enjoy playing with peers? ◯ Yes ◯ No
How do they initiate play? _____

Strengths and Interests

What are your child's favorite toys or topics? _____

What are your child's greatest strengths? _____

Are there specific sensory preferences? _____

Educational History

Does your child attend daycare, preschool, or school? ◯ Yes ◯ No
If so, please name. _____
Do they currently have an IEP or 504 plan? ◯ Yes ◯ No

Are they receiving other services? _____

Signature of Parent/Guardian: _____ **Date:** _____

Availability

If treatment is recommended, please clarify availability:

Mondays	☐ Morning (8:00 AM to 12:00 PM)	☐ Afternoon (12:30 PM to 3:00 PM)	☐ Evening (3:00 PM to 6:00 PM)
Tuesdays	☐ Morning (8:00 AM to 12:00 PM)	☐ Afternoon (12:30 PM to 3:00 PM)	☐ Evening (3:00 PM to 6:00 PM)
Wednesdays	☐ Morning (8:00 AM to 12:00 PM)	☐ Afternoon (12:30 PM to 3:00 PM)	☐ Evening (3:00 PM to 6:00 PM)
Thursdays	☐ Morning (8:00 AM to 12:00 PM)	☐ Afternoon (12:30 PM to 3:00 PM)	☐ Evening (3:00 PM to 6:00 PM)
Fridays	☐ Morning (8:00 AM to 12:00 PM)	☐ Afternoon (12:30 PM to 3:00 PM)	☐ Evening (3:00 PM to 6:00 PM)

Consent and Authorization

☐ **I authorize Empowered Through Communication to evaluate and treat my child.**

☐ **I authorize the release of information to the primary care physician listed above.**

Print name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____