JANINE STIENE SPEECH LANGUAGE PATHOLOGY, P.C.

Main Phone: 631-689-6858 Fax: 631-751-6027

Patient Name: _____ **Date of Birth:** _____

Nickname:_____ **Reason For Eval:**_____ **Recommended By:**_____

In your own words, describe concerns and reason for testing:

Child lives with (check one):					
Birth Parents		Foster Parents		Family Member: _____	
Adoptive Parents		One Parent		Other:_____	

Prenatal History			
Duration of Pregnancy:	Length of Delivery:		Type of Delivery:
Any trauma, illness, condition, or accident during pregnancy or delivery? (if yes, explain):			
Any loss of oxygen to child during delivery? (if yes, how long):			

Immediately Following Birth	**Y/N**
Blueish appearance	
Bruising	
Jaundice appearance	
Spent time in NICU	
Difficulty latching	
Difficulty sucking	
Difficulty swallowing	
Consult with lactation specialist	
Bruising	
Jaundice intervention	
Spent time in NICU	
APGAR WNL	
Alternative form of nutrition Req'd	
Reliant on Oxygen	
Consultation w/ any add'l med. Prof.	
Other:	

Developmental History	**Early**	**Average**	**Late**	**Never**
Hold head up				
Roll over				
Sit up (no support)				
Crawl				
Walk unaided				
Babble				
Speak 1st Word				
Use sentences				

Family History	
Has anyone in the family ever:	**Y/N**
Received speech therapy	
Received myofunctional therapy	
Had braces	
Has palate expander	
Suffered from TMJ or TMJ symptoms	
Suffered from sleep apnea	

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Feeding History	Y/N	Age Started / Discontinued
Breast Fed		
Bottle Fed		
Difficulties with baby cereal		
Difficulties with Stage 1 foods		
Difficulties with Stage 2 foods		
Difficulties with Stage 3 foods		
Difficulties with finger foods		
Texture/consistency aversion		
Combo Breast/Bottle		
Difficulty w/ lactose difficulty		
Trialed variety of formulas		
Gassy		
Colic		
Reflux interventions trialed (ie: Zantac/Gripe Water)		
Trialed a variety of bottle types		
Trialed a variety of nipple types		
Trialed a variety pacifier types		
Sippy cup use		
Straw cup use		
Drinks from open cup		

Current Feeding History:	Y/N	Current Feeding History:	Y/N
Eats steak		Drinks excessively at meals	
Eats yogurt with pieces		Over stuffs	
Eats sandwiches		Gags easily	
Eats condiments		Chews excessively	
Eats mashed potatoes		Spits out food	
Eats apple sauce		Ever choke	
Eats eggs		Eats soup (broth)	
Eats hard foods		Eats soup (contents)	
Eats soft foods		Eats pasta with sauce	
Eats crunchy foods		Eats deli meat on sandwich	
Eats chewy food		Eats chicken(not just nuggets)	
Eats slow		Eats cereal w/ milk	
Eats Burger on bun		Eats Veggies	
Eats Hot dog on bun		Eats Pizza	

Background History

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Problem	Y/N	How often/when/why:	Does your child:	Current	Past	Never
Ear infections			Bite nails			
Myringotomy tubes			Mouth objects(ie:shirt,pencil)			
Strep throat			Have a bite breaker			
Tonsillitis			Have a palate expander			
Tonsillectomy			Have braces			
Adenoidectomy			Have a retainer			
Bronchitis			Move around a lot while asleep			
Pneumonia			Snore			
Croup			Suck their tongue			
Asthma			Suck their thumb/finger			
Use a nebulizer			Bite their lips			
Sinus infections			Have chapped lips			
Allergies			Lick their lips			
Grind their teeth			Prolonged pacifier use(1+ yrs)			
Clench their teeth			Prolonged thumb/finger sucking			
Have TMJ pain						
Has difficulty falling asleep						
Has difficulty waking in a.m						
Difficulty attending to task						
Wet the bed						

Other:

Medical History:				
Has Patient Ever:	**Y/N**	**Why?**	**Where?**	**When?**
Broken any bones?				
Had stitches?				
Had surgery?				
Suffered from trama				

Does patient take any medications on a regular basis? Why? Type?

Is there any additional information which you feel would better help us to understand your child? _____

_____

Did your child ever receive early intervention, preschool, or special education services to support their development? (please explain)_____

Does your child seem to have any difficulty understanding speech sounds: (If yes, explain) _____

_____

At what age did your child start school?_____ Were any grades repeated?_____

Are there any school subjects which they have particular difficulties?_____

How does your child get along with others?_____

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Motor Function

Does your child have any sensitivity to different textures on their hands/feet/face/other body parts? _____

If yes, please explain._____

Does your child have any difficulties manipulation their body in space? If yes, please explain._____

Does your child have any difficulty manipulating small objects with their hands?_____

Does your child appear to have an awkward gait? _____

Does your child use their hands/eyes for anything other than their typical functions? (flapping, staring, biting)_____

Does your child present with any behaviors:_____

Interventions:			
Tested:	**When:**	**Why:**	**Outcome:**
For speech therapy			
For fine motor concerns(OT)			
For gross motor concerns(PT)			
For academic Support			
For attentional issues			
For behavioral concerns			
By a neurologist			
By an audiologist			
By a neuropsychologist			
To implement an IEP			
By an orthodontist			
By an ENT			
By an oral surgeon			