Special Learning Center

INFORMATION AND PERSONAL HISTORY

Date: _____ Sex:_____

Child's Name:_____ Parent Email:_____

Date of Birth:_____ Parent Phone:_____

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

Pregnancy & Delivery

Vaginal ☐ Cesarean ☐

Born at how many weeks gestation:_____ Birth weight:_____

Describe any pregnancy, labor and/or delivery complications:

_____

_____

_____

Time in NICU:

_____

_____

_____

Family Life

Family Members (Name, relation and age):

_____

_____

_____

Primary Caregiver(s):_____

Health Information

Allergies:

_____

_____

Hospitalizations:

_____

_____

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Surgeries:

_____

_____

Medical Diagnoses:

_____

_____

Precautions we need to be aware of:

_____

_____

Medications:

_____

_____

Equipment: (glasses, orthotics, hearing aides, wheelchair, stander, gait trainer, etc…)

_____

_____

Sleeping Schedule:

_____

_____

History of Services

Does your child receive any other services?
If so, please provide a copy of your child's IEP (school document) or IFSP (First Steps document)

_____

_____

Hearing and Vision

Has your child ever hearing tested? If yes, what were the results?_____

Has your child ever vision tested? If yes, what were the results? _____

Has your child had any ear infections? How many?_____

Does/did your child have PE tubes placed in his/her ears?_____

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SPEECH AND LANGUAGE DEVELOPMENT

Do any close family members have a history of the following? (Please check all that apply)

- ☐ Speech/Language Difficulties
- ☐ Learning Disabilities (ex: dyslexia)
- ☐ Hearing Impairment/Deafness

If you selected any of the above, please explain who this applies to:

_____

Is any language other than English spoken in the home? YES NO

If yes, which language: _____

Does the child speak this language? YES NO

Does the child understand this language? YES NO

Which language does the child prefer to speak at home? _____

Have you ever questioned your child's ability to hear normally? YES NO

If yes, please explain: _____

Is your child aware of, or frustrated by, any speech/language difficulties? YES NO

If yes, please describe: _____

Please check all that apply:

- ☐ Repeats sounds, words, or phrases over and over
- ☐ Understands words
- ☐ Understands sentences
- ☐ Understands conversation
- ☐ Retrieves/points to common objects upon request
- ☐ Follows 1-step directions
- ☐ Follows 2-step directions
- ☐ Responds correctly to yes/no questions
- ☐ Responds correctly to 'wh' questions
- ☐ Asks questions of others

My child currently communicates using…

- ☐ Crying or tantrums
- ☐ Body language (i.e. pointing, looking, gesturing)
- ☐ Sounds (i.e. vowel sounds, grunting)
- ☐ Single words
- ☐ 2 to 4 word sentences
- ☐ Sentences longer than 4 words (provide example): _____
- ☐ Other:_____

If your child typically is using words or sentences, please indicate if he/she is difficult to understand:

By You: YES NO By Others: YES NO

If yes, how? (Check all that apply)

Speech Sounds

- ☐ Omits sounds
- ☐ Distorts sounds
- ☐ Substitutes sounds
- ☐ Other:_____

Language

- ☐ Word order
- ☐ Omits words
- ☐ Speaks in only words/phrases
- ☐ Other:_____

Fluency/Voice

- ☐ Word or sound repetitions
- ☐ Frequent and/or long pauses
- ☐ Frequent use of "um" or "uh"
- ☐ Unusual vocal quality or volume

Estimate the percentage of time your child's speech is understood: By You:_____% By Others:_____%

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MOTOR DEVELOPMENT

What physical activities are difficult for your child? (Check all that apply)

- ☐ Tolerating laying on their belly
- ☐ Sitting up independently
- ☐ Moving into/out of positions (ex. Move from lying down to sitting up)
- ☐ Standing with assistance
- ☐ Standing without assistance
- ☐ Walking with assistance (physical assistance or an assistive device)
- ☐ Walking without assistance
- ☐ Walking up and down stairs
- ☐ Running
- ☐ Grasping objects
- ☐ Reaching for objects
- ☐ Releasing objects
- ☐ Other:_____

  _____

  _____

What daily activities are difficult for your child? (Check all that apply)

- ☐ Bathing
- ☐ Toileting
- ☐ Dressing
- ☐ Self-Feeding
- ☐ Sleeping
- ☐ Using utensils
- ☐ Other:_____

  _____

  _____

What sensory difficulties does your child experience? (Check all that apply)

- ☐ Playing with various mediums/textures
- ☐ Seeking excessive input (ex. Running into things, spinning, etc.)
- ☐ Aversions to food textures
- ☐ Other:_____

  _____

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Help Us Get to Know Your Child

What are your child's gifts/strengths?

_____

_____

_____

_____

What do you enjoy doing most with your child?

_____

_____

_____

What are your child's favorite things?

_____

_____

_____

Why are you referring your child to therapy?

_____

_____

_____

Therapy Goals

What are your goals for your child?

_____

_____

_____

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Prescription to Evaluate and Treat

We are excited you have chosen The SKIP Clinic for your child to receive outpatient therapy services. In order for our therapists to see your child, we need a prescription from your child's physician to evaluate and treat your child.

Please have your child's physician's office fax a prescription to the Special Learning Center at (573)636-3247.

We prefer the prescription to say "**Physical therapy: evaluate and treat**" or "**Occupational therapy: evaluate and treat**" or **"Speech therapy: evaluate and treat."** If there are any precautions or contraindications to treatment, your physician should indicate those on the prescription. If your physician asks how many visits to put on the prescription, please leave that part blank.

Thank you for your assistance in getting these as quickly as possible so that we may initiate treatment.

Thanks,

The SKIP Clinic Team