Grow & Tell, LLC

Speech-Language Pathology & Occupational Therapy Services
Phone: 717-512-2841
www.growtellslp.com

Please return this form to jessicaover@growtellslp.com

CLIENT IN-TAKE & MEDICAL HISTORY FORM

Demographic Information:	
Client Name:	Primary Care Physician (PCP):
DOB:	PCP Address:
Client Home Address:	PCP Phone Number:
Primary Health Insurance □ Capital Blue Cross □ Highmark □ Other: _____ Primary Health Insurance □ Member ID №: □ Group №:	How did you hear about us? □ Insurance □ Friend/Family □ Primary Care Doctor □ Website □ Other: _____
Primary Language Spoken in the home: Are there any additional languages spoken in the home?	Is your child up to date with immunizations? If no; please describe why.

Parent/Guardian Information:		
	Mother	**Father**
Name		
Address		
Primary Phone Number		
Email Address		
Primary and/or Secondary Languages Spoken		

Sibling Information:			
Name	**Age**	**Did he/she receive Speech-Language therapy before?**	**If Yes, what did they receive therapy for?**
		YES NO	
		YES NO	
		YES NO	
		YES NO	
		YES NO	

Statement of Problem/Concern:

Please describe the areas you are concerned with:

When and by whom was the problem first noticed?

Has your child received any previous help for the areas of concern? □ YES/ □ NO
If yes, please list the type of help, dates of services and the name of the professional or agency involved.

MEDICAL HISTORY:

Are there any family members or relatives who have or have had Speech, Language, Voice, Hearing, Reading or Writing difficulties? □ YES/ □ NO
If yes, please provide additional information (i.e. who and what type)

Pregnancy & Birth History:
Was the baby full term? □ YES/ □ NO
If no, how early or late?

Were there any complications during delivery? □ YES/ □ NO
If yes, please provide further information.

Did the baby require oxygen? □ YES/ □ NO

Baby's weight:
Baby's length:

Were there any complications immediately following the birth or during the first few weeks of life?
Please circle all that apply

Difficulty breathing	Difficulty sucking	Difficulty feeding	Seizures
Birth defect	Transfusions	Extended Hospital stay	Rubella
Herpes	Syphilis	Sepsis	

Other (please specify):

Please describe any serious illnesses, injuries or physical problems your child has experienced.

Does your child have allergies? □ YES/ □ NO
If yes, please list.

Is your child currently taking medications? □ YES/ □ NO
If Yes, please list type and dosage.

Is your child currently being treated for a medical condition? □ YES/ □ NO
If Yes, please describe.

Has your child ever been hospitalized? □ YES/ □ NO
If yes, please describe.

Does your child have difficulty eating (drooling, chewing, choking, pocketing food in cheeks)? □ YES/ □ NO
If yes, please describe.

Has your child's hearing ever been tested? □ YES/ □ NO
If yes, please provide when, where and the results of the assessment.
Do you have a copy of the results available?

Does your child seem to have adequate hearing? □ YES/ □ NO

LANGUAGE DEVELOPMENT:

At what age did the following occur?

Milestone	*Age*	*Additional Information/ Explanation*
Respond to own name		
Followed simple directions		
Recognized names of familiar objects		
Pointed to eyes, nose and mouth when name		
Babbled		
Said first word		
Had a vocabulary of 10 words		
Combined two-words		
Talked in short sentences		
Said full name		
Verbally related events/experiences		

At the present time:
Does your child follow directions correctly? □ YES/ □ NO
If you answer is No, please provide further information explanation of what your child does in place of this behavior.

Does your child respond to questions appropriately? □ YES/ □ NO
If your answer is No, please provide further explanation of what your child does in place of this behavior.

Do you need to use gestures? □ YES/ □ NO *If Yes, please provide further explanation.*

Do you need to repeat yourself? □ YES/ □ NO *If Yes, please provide further explanation.*

Do you need to speak in short, simple sentences? □ YES/ □ NO
If Yes, please provide further explanation or examples.

How does your child communicate his/her wants and needs?

SPEECH DEVELOPMENT:

How much of your child's speech do you understand?
10% 25% 50% 75% 100%

How much of your child's speech do unfamiliar listeners understand?
10% 25% 50% 75% 100%

Does a parent need to interpret for others? □ YES/ □ NO
If Yes, please provide further explanation.

Does your child grope for words or use the wrong word? □ YES/ □ NO
If Yes, please describe your child's behaviors.

Does your child's voice have a nasal or harsh quality? □ YES/ □ NO

Additional Comments:

SOCIAL and BEHAVIORAL DEVELOPMENT:

What is the average length of time your child can stay playing at one activity?

What activities seem to hold your child's attention for the shortest periods of time?

What activities seem to hold your child's attention for the longest periods of time?

What is/are your child's preferred play activities?

Does your child avoid any play activities? □ YES/ □ NO
If Yes, please describe.

Is your child toilet trained? □ YES/ □ NO
If Yes, what age did they become toilet trained?

EDUCATIONAL HISTORY:

Name of the school your child is currently attending:

Grade:

Full time? □ YES/ □ NO
If no, please list other daycares/schools they attend and how often.

What are your child's best subjects?

What subjects does your child require the most help in?

Does your child receive services from school? YES/NO
If yes, please provide how often.

Please provide copies of any assessment/treatment reports and/or health records pertaining to your child's appointment today.* ***Thank-you!*