

EASTSIDE READING & LANGUAGE THERAPY, LLC.

Today's Date _____

Child's Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Grade: _____ School: _____

Reason for seeking this evaluation/treatment _____

Referred by: _____

Person completing the form: _____

Relationship to the child: _____

Parent/Guardian's Name: _____ Relationship to child _____

Home Address: _____

City, State, Zip: _____

Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email: _____

Parent/Guardian's Name: _____ Relationship to child _____

Home Address: _____

City, State, Zip: _____

Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email: _____

Emergency Contact Name: _____ Relationship to child _____

Emergency Contact Phone Number _____

Child's Physician: _____

Physician's Phone: _____

Physician's Address: _____

Please describe your concerns about your child.

Family Background

Does your child have siblings or are there other children in the home?

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Language(s) spoken in the home: _____

If more than one language, who speaks the other language(s)? _____

Describe your child's use/understanding of the language(s):

Is there any history of dyslexia, learning disabilities, speech and language delays, and/or ADHD in the immediate or extended family? If yes, please describe:

Is there anything additional you would like to share about the family / home environment?

Health History

Prenatal Health History:

Were there any infections, illnesses, or other complications during pregnancy? ☐Yes ☐No

Describe: _____

List any medications or drugs (including alcohol) taken during pregnancy:

Child's Medical History:

At how many weeks gestation was your child born? _____ weeks (40 weeks is typical)

Your child was _____ lbs _____ oz and _____ inches at birth.

Were there any complications or concerns during labor or delivery? If yes, please describe:

General impression of your child's gross motor development. (e.g., Sitting up, crawling, walking, self-fed)

☐ Early ☐ Expected Time ☐ Delayed

If delayed, please describe: _____

General impression of your child's fine motor development. (e.g., grasping small objects, pencil grip, handwriting)

☐ Early ☐ Expected Time ☐ Delayed

If delayed, please describe: _____

General impression of your child's spoken language development. (e.g., First word, two word combinations, sentences)

☐ Early ☐ Expected Time ☐ Delayed

If delayed, please describe: _____

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

What percentage of your child's speech do people outside the family understand? _____ %

If less than 95%, please describe the errors that are impacting your child's intelligibility: (e.g., "wike" for "like") _____

Has your child's hearing been evaluated? ☐ Yes ☐ No If yes, please indicate test dates and

results: _____

Does your child have a history of ear infections, PE tubes, etc. or use hearing aids? ☐ Yes ☐ No

If yes, please describe: _____

Has your child's vision been recently evaluated? ☐ Yes ☐ No If yes, please indicate test dates and

results: _____

Has your child participated in any formal testing or therapy with a speech-language pathologist, psychologist, occupational therapist, physical therapist, and/or learning specialist? ☐ Yes ☐ No

If yes, please describe who conducted the testing/therapy, when the testing/therapy occurred, and the results: _____

Is your child currently on any medications? ☐ Yes ☐ No If yes, please list medication name and reason for medication:

Medication 1: _____

Medication 2: _____

Medication 3: _____

Medication 4: _____

Does your child have any known allergies? ☐ Yes ☐ No

Describe: _____

Is your child up to date with immunizations: ☐ Yes ☐ No

Check and describe all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety/stress | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> Behavior Issues | <input type="checkbox"/> Brain injury |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Cardiac issues | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Enlarged Tonsils/Adenoids | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> OCD | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sensory issues |
| <input type="checkbox"/> Sleep issues | <input type="checkbox"/> Tongue tie | <input type="checkbox"/> Oral Habits (e.g., finger or shirt sucking) |

Please describe:

Are there any other health concerns?

Educational History

Is your child currently enrolled in school? ☐ Yes ☐ No

School History (List most recent first)

Year/Grade	School Name	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have an IEP, IFSP, 504B plan or receive any additional services at school? ☐ Yes ☐ No

If yes, please describe: _____

Does your child receive tutoring? ☐ Yes ☐ No

If yes, please indicate the subject, for how long, and the tutor's/company's name.

What concerns, if any, have been expressed by your child's teachers, school specialist, or tutor?

What is your child's strongest subject in school?

What is your child's weakest subject in school?

What is your child's favorite subject or part of the school day?

What is your child's attitude towards school?

What kind of environment, feedback, and/or activities have you noticed help/motivate your child to learn?
What is de-motivating?

Please indicate any areas of difficulty that your child currently has or has had in the past. ***

Speech Sound Awareness	
<input type="checkbox"/>	doesn't understand and enjoy rhymes
<input type="checkbox"/>	doesn't easily recognize that words may begin with the same sound
<input type="checkbox"/>	has difficulty counting the syllables in spoken words
<input type="checkbox"/>	has difficulty clapping hands or tapping feet in rhythm with songs and/or rhymes
<input type="checkbox"/>	demonstrates problems learning sound-letter correspondences

Word Retrieval	
<input type="checkbox"/>	has difficulty retrieving a specific word (e.g., calls a sheep a "goat" or says "you know a wooly animal")
<input type="checkbox"/>	shows poor memory for classmates' names
<input type="checkbox"/>	speech is hesitant, filled with pauses or vocalizations (e.g., "um" "you know")
<input type="checkbox"/>	frequently uses words lacking specificity (e.g., "stuff," or "thing,")
<input type="checkbox"/>	has problems remembering/retrieving verbal sequences (e.g., days of the week alphabet)

Verbal Memory	
<input type="checkbox"/>	has difficulty remembering instructions or directions
<input type="checkbox"/>	shows problems learning names of people or places
<input type="checkbox"/>	has difficulty remembering the words to songs or poems
<input type="checkbox"/>	has problems learning a second language

Speech Productions/Perception	
<input type="checkbox"/>	has problems saying common words with difficult sound patterns (e.g., animal, cinnamon, specific)
<input type="checkbox"/>	mishears and subsequently mispronounces words or names
<input type="checkbox"/>	confuses a similar sounding word with another word (e.g., saying "The Entire State Building is in New York.")
<input type="checkbox"/>	combines sound patterns of similar words (e.g., saying "escavator" for escalator)

<input type="checkbox"/>	shows frequent slips of the tongue (e.g., saying “brue blush” for blue brush
<input type="checkbox"/>	has difficulty with tongue twisters (e.g., she sells seashells)

Comprehension

<input type="checkbox"/>	Difficulty completing all parts of a multi-step direction or request
<input type="checkbox"/>	requests multiple repetitions of instructions/directions with little improvement in comprehension
<input type="checkbox"/>	has difficulty understanding questions
<input type="checkbox"/>	difficulty with listening comprehension of age appropriate material
<input type="checkbox"/>	difficulty with reading comprehension of age appropriate material
<input type="checkbox"/>	has difficulty making inferences, predicting outcomes, drawing conclusions
<input type="checkbox"/>	lacks understanding of spatial terms such as left-right, front-back

Expressive Language

<input type="checkbox"/>	talks in short sentences
<input type="checkbox"/>	makes errors in grammar (e.g., “he goed to the store” or “me want that”
<input type="checkbox"/>	lacks variety in vocabulary (e.g., uses “good” to mean happy, kind, polite)
<input type="checkbox"/>	has difficulty giving directions or explanations (e.g., may show multiple revisions or dead ends)
<input type="checkbox"/>	relates stories or events in a disorganized or incomplete manner
<input type="checkbox"/>	may have much to say, but provides little specific detail
<input type="checkbox"/>	has difficulties with the rules of conversation, such as turn taking, staying on topic, indicating when he/she does not understand

Additional domains

<input type="checkbox"/>	difficulty with math facts
<input type="checkbox"/>	difficulty with math word problems
<input type="checkbox"/>	difficulty with handwriting
<input type="checkbox"/>	difficulty with spelling
<input type="checkbox"/>	poor studying habits or difficulty completing homework
<input type="checkbox"/>	lacks interest in reading and shared reading activities

*** This checklist was prepared by Hugh W. Catts, University of Kansas. Some descriptors have been taken from *Language for Learning: A Checklist for Language Difficulties*, Melbourne, Australia; *OZ Child* and others have been changed to suit the purpose of this form.

Please describe any other difficulties not mentioned above:

Outside of academics, what are your child's strengths?

What are your child's interests/activities/hobbies? _____

What are your goals for your child over the next 6 months? _____

What are your goals for your child over the next 5 years?

Is there anything else that is important for us to know about your child?

Thank you for completing this form.