

Progress Form

| | | | | | |
|--------------|---|----------------|---------------|---|--------------------|
| Patient Name | : | Alston Rebello | Emirates ID | : | 784-1991-2906159-3 |
| File No | : | 17 | DOB | : | 1996-06-20 |
| Nationality | : | Indian | Date | : | 2024-02-01 |
| Gender | : | Male | Doctor's Name | : | Doctor Vision |

Siblings h

Informant:h

Date of Evaluation1/13/2024
12:00:00 AM

Medical Diagnosis: h

Presenting Symptoms: h

HEARING STATUS:h

| | | | |
|--------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------|
| <input checked="" type="checkbox"/> Normal | <input checked="" type="checkbox"/> Middle ear effusion | <input checked="" type="checkbox"/> Sensory-neural hearing loss | <input checked="" type="checkbox"/> Conductive hearing loss |
| Devices/Aids | <input checked="" type="checkbox"/> Nil | <input checked="" type="checkbox"/> Hearing Aid | <input checked="" type="checkbox"/> Cochlear Implant |
| | | | <input checked="" type="checkbox"/> FM System |

Last Hearing Test:h

OPME

| | |
|------------|----|
| Overall | h |
| Teeth | h |
| Lips | h |
| Tongue | hh |
| Jaw | h |
| S/H Palate | h |
| Cheeks | h |

SWALLOWING

| | | |
|-----------------------------------------|--------------------------------------|--------------------------|
| History of aspiration | <input checked="" type="radio"/> Yes | <input type="radio"/> No |
| Current eating or drinking difficulties | <input checked="" type="radio"/> Yes | <input type="radio"/> No |
| Dysphagia | <input checked="" type="radio"/> Yes | <input type="radio"/> No |

SPEECH:

| | | | |
|--------------------------------------------|-----------------------|------------------------------------------------|---------------|
| <input checked="" type="checkbox"/> Verbal | | <input checked="" type="checkbox"/> Non Verbal | |
| Phonological processes | Intelligibility scale | Rate of speech | Voice quality |

| | | | |
|--------------------------------------------------|------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------|
| <input checked="" type="checkbox"/> Omission | <input checked="" type="checkbox"/> Normal | <input checked="" type="checkbox"/> Normal | <input checked="" type="checkbox"/> Normal |
| <input checked="" type="checkbox"/> Addition | <input checked="" type="checkbox"/> Mild | <input checked="" type="checkbox"/> Very Slow | <input checked="" type="checkbox"/> Horse |
| <input checked="" type="checkbox"/> Substitution | <input checked="" type="checkbox"/> Mild- Moderate | <input checked="" type="checkbox"/> Slow | <input checked="" type="checkbox"/> Breathy |
| <input checked="" type="checkbox"/> Distortion | <input checked="" type="checkbox"/> Moderate | <input checked="" type="checkbox"/> Slightly Fast | <input checked="" type="checkbox"/> Harsh |
| <input checked="" type="checkbox"/> Metathesis | <input checked="" type="checkbox"/> Severe | <input checked="" type="checkbox"/> Fast | <input checked="" type="checkbox"/> Hypo nasal |
| <input checked="" type="checkbox"/> Devoicing | <input checked="" type="checkbox"/> Not Intelligible | <input checked="" type="checkbox"/> Very Fast | <input checked="" type="checkbox"/> Hyper nasal |
| <input checked="" type="checkbox"/> Other | <input checked="" type="checkbox"/> Other | <input checked="" type="checkbox"/> Other | <input checked="" type="checkbox"/> Other Vocalization |

| | |
|--------------------|---|
| Behaviors | h |
| Requesting | h |
| Sitting tolerance: | h |

ATTENTION & ACTIVITY LEVEL

| | | | |
|------------------------------------------------|-----------------------------------------------------|-------------------------------------------------|----------------------------------------------------------|
| <input checked="" type="checkbox"/> Attentive | <input checked="" type="checkbox"/> Needs prompt | <input checked="" type="checkbox"/> Hyperactive | <input checked="" type="checkbox"/> Short attention span |
| <input checked="" type="checkbox"/> Distracted | <input checked="" type="checkbox"/> Not cooperative | <input checked="" type="checkbox"/> Clumsy | <input checked="" type="checkbox"/> Other |



LANGUAGE SCREENING

*Receptive language:

| | |
|----------------------------------------------------------------------|-------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Responds to sounds | <input checked="" type="checkbox"/> Understand basic pronouns |
| <input checked="" type="checkbox"/> Babbling string of syllables | <input checked="" type="checkbox"/> Understand basic prepositions |
| <input checked="" type="checkbox"/> Imitation of sounds | <input checked="" type="checkbox"/> Understand basic plural |
| <input checked="" type="checkbox"/> Variation of pitch and loudness | <input checked="" type="checkbox"/> Understand regular plurals |
| <input checked="" type="checkbox"/> Comprehends at least 10-20 words | <input checked="" type="checkbox"/> Understand irregular plural |
| <input checked="" type="checkbox"/> Comprehends at least 20-50 | <input checked="" type="checkbox"/> Understand basic negatives |
| <input checked="" type="checkbox"/> Comprehends at least 50-80 | <input checked="" type="checkbox"/> Understand simple adjectives |
| <input checked="" type="checkbox"/> Responds to requests | <input checked="" type="checkbox"/> Understands common verbs |
| <input checked="" type="checkbox"/> Understands 'No' | <input checked="" type="checkbox"/> Understands present continues verbs |
| <input checked="" type="checkbox"/> Follows simple one-word commands | <input checked="" type="checkbox"/> Understands past continues verbs |
| <input checked="" type="checkbox"/> Follows 1 step commands | <input checked="" type="checkbox"/> Understands basic possessives |

| | | | | |
|------------------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> Understand basic pronouns | <input checked="" type="checkbox"/> Able to sequence 3 part story | | | |
| <input checked="" type="checkbox"/> Identifies between 2 items | <input checked="" type="checkbox"/> Able to sequence more than 6 part story | | | |
| <input checked="" type="checkbox"/> Identifies between 4-6 items | <input checked="" type="checkbox"/> Able to solve simple problems | | | |
| <input checked="" type="checkbox"/> Able to choose between 2 or more options | <input checked="" type="checkbox"/> Appropriate pointing responses | | | |
| *Expressive language: | | | | |
| <input checked="" type="checkbox"/> Uses gestures predominantly | <input checked="" type="checkbox"/> Uses jargons | | | |
| <input checked="" type="checkbox"/> Produces less than 10 words | <input checked="" type="checkbox"/> Produces 10-50 words | | | |
| <input checked="" type="checkbox"/> Produces 50-150 words | <input checked="" type="checkbox"/> Produces 150-300 words | | | |
| <input checked="" type="checkbox"/> Produces 1 word phrases | <input checked="" type="checkbox"/> Responds to YES \ No questions | | | |
| <input checked="" type="checkbox"/> Produces 2 word sentences | <input checked="" type="checkbox"/> Naming of everyday objects 5-20s | | | |
| <input checked="" type="checkbox"/> Produces 3 word sentences | <input checked="" type="checkbox"/> Describe everyday events | | | |
| <input checked="" type="checkbox"/> Produces 4 word sentences or more | <input checked="" type="checkbox"/> Produces common adjectives | | | |
| *Pragmatics screening: | | | | |
| <input checked="" type="checkbox"/> Able to imitate others | <input checked="" type="checkbox"/> Listen and wait | | | |
| <input checked="" type="checkbox"/> Pretend play | <input checked="" type="checkbox"/> Cause and effect | | | |
| <input checked="" type="checkbox"/> Play within rules | <input checked="" type="checkbox"/> Initiate a conversation | | | |
| <input checked="" type="checkbox"/> Taking turns | <input checked="" type="checkbox"/> Maintain a conversation | | | |
| <input checked="" type="checkbox"/> Greeting and respond when called | <input checked="" type="checkbox"/> Maintain a good eye contact | | | |
| *Social interaction: | | | | |
| | Poor | Fair | Good | Excellent |
| Peers | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Adults | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| *Literacy skills: | | | | |
| Reading | | Writing | | |
| <input checked="" type="checkbox"/> A Recognize letters, words | | <input checked="" type="checkbox"/> Scribbling | | |
| <input checked="" type="checkbox"/> Choosing | | <input checked="" type="checkbox"/> Tracing | | |

| | | | |
|-----------------------------------------------------|-------|--------------------------------------------------------------|--|
| <input checked="" type="checkbox"/> Naming/ Reading | | <input checked="" type="checkbox"/> Writing | |
| *Use Assistive Technology | | | |
| <input checked="" type="radio"/> Yes | | <input type="radio"/> No | |
| | | If yes which device:h | |
| EDUCATIONAL STATUS | | | |
| <input checked="" type="checkbox"/> At home | | <input checked="" type="checkbox"/> Preschool | |
| | | <input checked="" type="checkbox"/> Special education center | |
| <input checked="" type="checkbox"/> Public school | | <input checked="" type="checkbox"/> Regular nursery | |
| | | <input checked="" type="checkbox"/> Others | |
| GENERAL FINDINGS: | | h | |
| TEST RESULTS: | | h | |
| SN | Goals | Progress | |
| 1. | h | h | |
| 2. | h | h | |
| 3. | h | h | |
| 4. | h | h | |
| 5. | h | h | |
| 6. | h | h | |
| RECOMMENDATIONS: | | h | |

| | |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| Sign here, only if all of your questions have been answered to your satisfaction | |
| PATIENT | DOCTOR |
|  |  |
| Patient Name Alston Rebello Date 2024-02-01 11:00 | Doctor Name Doctor Vision - Speech Therapy (DHA101) Date 2024-02-01 11:00 |