

# CENTER FOR SPEECH & LANGUAGE, INC.

RHONDA H. HEMPHILL, M.S., C.C.C.  
AND ASSOCIATES

## CLIENT/PATIENT CONSENT FOR EVALUATION AND/OR TREATMENT

I hereby give my consent for \_\_\_\_\_ to be evaluated  
and/or treated by Center for Speech & Language, Inc.

\_\_\_\_\_  
Signature of Client/Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Patient's Name

\_\_\_\_\_  
Print Name of Client/Patient or Legal Guardian

## CLIENT/PATIENT CONSENT FOR RECORDING

I hereby give my consent for \_\_\_\_\_ to be video  
and/or audio taped during evaluation and/or treatment by Center for Speech & Language,  
Inc.

\_\_\_\_\_  
Signature of Client/Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Patient's Name

\_\_\_\_\_  
Print Name of Client/Patient or Legal Guardian

**DOES YOUR CHILD HAVE AN ALLERGY TO LATEX?** \_\_\_\_\_ **YES** **NO**

**If your child does have an allergy to latex, PLEASE LET CLINICIAN KNOW IMMEDIATELY**

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## INITIAL EVALUATION QUESTIONNAIRE (CHILDREN)

Today's Date \_\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ E-mail address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Education \_\_\_\_\_

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ E-mail address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Education \_\_\_\_\_

Person responsible for payment \_\_\_\_\_

Child's doctor/pediatrician & address \_\_\_\_\_

Child's dentist \_\_\_\_\_

Who referred you to this Center ? \_\_\_\_\_

What is their relationship to you (i.e., teacher, friend, family) \_\_\_\_\_

Other Children in family:

<u>Name</u>	<u>Date of Birth</u>	<u>Age</u>	<u>School</u>	<u>Grade</u>	<u>Speech/lang. Problem?</u>
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Describe the problem for which testing is being requested \_\_\_\_\_  
\_\_\_\_\_

Possible cause \_\_\_\_\_

When did you first notice a problem with your child's speech or language? \_\_\_\_\_  
\_\_\_\_\_

How has the problem changed over time? \_\_\_\_\_

Does your child think he/she has a problem? \_\_\_\_\_  
\_\_\_\_\_

What have you done at home to help your child? \_\_\_\_\_  
\_\_\_\_\_

Has it worked? \_\_\_\_\_

Has your child ever had speech or language testing? \_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_

What were the results? \_\_\_\_\_

Does anyone else in the family have a speech, language or hearing problem? If so, please describe. \_\_\_\_\_

What information do you hope to get from this evaluation? \_\_\_\_\_  
\_\_\_\_\_

**BIRTH HISTORY**

Was child adopted? \_\_\_\_\_ At what age? \_\_\_\_\_

Health of mother during pregnancy \_\_\_\_\_

Illnesses, accidents, drugs or other unusual factors related to pregnancy \_\_\_\_\_  
\_\_\_\_\_

Was the child full term? \_\_\_\_\_ If no, how many weeks early? \_\_\_\_\_

Delivered by Caesarean section? \_\_\_\_\_ Were forceps used? \_\_\_\_\_ Breech? \_\_\_\_\_

Condition of child after birth \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Give approximate age when child:

First crawled \_\_\_\_\_ First sat without support \_\_\_\_\_ Walked alone \_\_\_\_\_

Dressed Self \_\_\_\_\_ Fed self \_\_\_\_\_ Ate solids \_\_\_\_\_

Gained control of bladder \_\_\_\_\_ Gained control of bowels \_\_\_\_\_

First used words \_\_\_\_\_ First combined words \_\_\_\_\_

Please explain if child had difficulty with any of the above events \_\_\_\_\_  
\_\_\_\_\_

Did child have any sucking, swallowing or other feeding problems? \_\_\_\_\_

Please explain \_\_\_\_\_

Which hand does the child prefer? \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_  
\_\_\_\_\_

Is child's general coordination good? \_\_\_\_\_

**HEALTH HISTORY**

Has your child had any of the following? Check and give dates.

**Date(s)**  
\_\_\_\_\_ Measles/Mumps \_\_\_\_\_  
\_\_\_\_\_ Chickenpox \_\_\_\_\_  
\_\_\_\_\_ Scarlet Fever \_\_\_\_\_  
\_\_\_\_\_ Meningitis \_\_\_\_\_  
\_\_\_\_\_ High Fevers \_\_\_\_\_  
\_\_\_\_\_ Seizures \_\_\_\_\_  
\_\_\_\_\_ Allergies \_\_\_\_\_  
\_\_\_\_\_ Accidents \_\_\_\_\_  
\_\_\_\_\_ ADD/ADHD \_\_\_\_\_  
\_\_\_\_\_ Operations \_\_\_\_\_  
\_\_\_\_\_ Asthma \_\_\_\_\_  
\_\_\_\_\_ Other \_\_\_\_\_

**Date(s)**  
\_\_\_\_\_ Ear Infections \_\_\_\_\_  
\_\_\_\_\_ Tubes \_\_\_\_\_  
\_\_\_\_\_ Suspected Hearing Loss \_\_\_\_\_  
\_\_\_\_\_ Dental Problems \_\_\_\_\_  
\_\_\_\_\_ appliances/braces/retainer/cavities  
or other \_\_\_\_\_  
\_\_\_\_\_ Vision Problems \_\_\_\_\_  
\_\_\_\_\_ glasses for near/far sightedness  
tracking/convergence \_\_\_\_\_  
\_\_\_\_\_ Frequent colds \_\_\_\_\_  
and sore throats \_\_\_\_\_

If you checked any of the above, please explain: \_\_\_\_\_  
\_\_\_\_\_

Has your child been hospitalized since birth? \_\_\_\_\_ For what reason? \_\_\_\_\_

\_\_\_\_\_ Please list any medications the child takes currently \_\_\_\_\_

Has your child ever been seen by a doctor other than his/her pediatrician (ex., Neurologist, Psychiatrist, ENT, etc.)? \_\_\_\_\_

For what problem? \_\_\_\_\_

Has your child ever been seen by a physical or occupational therapist? \_\_\_\_\_

What were the results? \_\_\_\_\_

**EDUCATION**

Name & address of current school \_\_\_\_\_ Grade \_\_\_\_\_

Names, places and dates of attendance of previous schools (including preschool)

<u>Name</u>	<u>City</u>	<u>Dates/Grades</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child currently attend day care? \_\_\_\_\_ For how long each day? \_\_\_\_\_

Has your child attended day care previously? \_\_\_\_\_

Does your child like school? \_\_\_\_\_

What are his/her easiest subjects? \_\_\_\_\_

What are his/her most difficult subjects? \_\_\_\_\_

Has your child ever failed or skipped a grade? \_\_\_\_\_

Has he/she ever had an intelligence test? \_\_\_\_\_

Does he/she now or has he/she in the past attended any special classes (speech therapy, reading, learning disabilities, gifted, etc.)? \_\_\_\_\_ Specify which and dates \_\_\_\_\_

What grades does your child receive? \_\_\_\_\_

**SOCIAL HISTORY**

Does your child live with both parents? \_\_\_\_\_

Has there been any changes in the family (death, divorce, severe or prolonged illness, frequent moves)? Describe \_\_\_\_\_  
\_\_\_\_\_

What language(s) other than English is spoken in the home? \_\_\_\_\_

Does your child play with other children in the neighborhood? \_\_\_\_\_

Does he/she prefer to play with older or younger children? \_\_\_\_\_

Does he/she prefer to play alone? \_\_\_\_\_

Does he/she play well with brothers and/or sisters? \_\_\_\_\_

What play activities does your child prefer? \_\_\_\_\_

What activities do you do with your child? \_\_\_\_\_

Has your child shown behaviors such as excessive crying, shyness, daydreaming, fighting, temper tantrums, lying, etc.? Please describe: \_\_\_\_\_  
\_\_\_\_\_

What discipline problems do you have with your child? \_\_\_\_\_  
\_\_\_\_\_

How is the child disciplined (spanking, punishment, etc.)? \_\_\_\_\_  
\_\_\_\_\_

Please list names and addresses of doctors, schools, agencies and/or other professionals to whom you would like the report sent. (If you don't have exact address, street name would be sufficient).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_