SPAULDING™
REHABILITATION HOSPITAL
CAPE COD

PATIENT IDENTIFICATION AREA

SPEECH/LANGUAGE PATHOLOGY GENERAL HEALTH FORM - Page 1 of 4

PEDIATRIC SPEECH/LANGUAGE PATHOLOGY GENERAL HEALTH FORM

PATIENT NAME: _____

DIAGNOSIS: _____

_____ AGE: _____

REFERRED BY: _____

PRIMARY PHYSICIAN (if different): _____

Address and phone number: _____

_____

SPECIALISTS YOUR CHILD IS CURRENTLY SEEING: _____

_____

_____

PARENT(S) / GUARDIAN(S) NAME(S) AND AGE(S): _____

_____

_____

SIBLING(S) NAME(S) AND AGE(S): _____

_____

_____

CASE HISTORY (Please circle and fill in details where appropriate)

1. Were there any problems with the pregnancy/delivery of your child? Yes No
   (If yes, please describe)

   _____

2. In your opinion, has your child attained developmental milestones (i.e., sitting unsupported, walking, first words, etc.) at the appropriate ages? Yes No
   (If no, please list areas of concern)

   _____

3. At what age did your child:

   Babble and coo (such as baba, gaga): _____

   Say first word that had meaning other than Mama or Dada: _____

   Use two-word phrases (such as “want cookie” or “more juice”): _____

   Use three word phrases (such as “daddy go work”): _____

4. What is your child’s health status? (circle) Excellent Good Fair Poor

5. Please indicate all medical problems we should be aware of, including actual medical diagnosis where applicable:

   _____

   _____

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PEDIATRIC SPEECH/LANGUAGE PATHOLOGY GENERAL HEALTH FORM

6. Please list any medical treatment/procedures/surgeries (with dates) that your child has received or is presently receiving.

_____

_____

_____

_____

7. Does your child have a history of ear aches or ear infections? (circle) Yes No

Has your child ever had tubes placed in the ears? (circle) Yes No

Please describe (indicate dates of tube placement if applicable) _____

_____

_____

8. Has your child had any (please circle and indicate date(s) and severity under those circled):

meningitis	scarlet fever	head injury	seizure disorder
measles	tuberculosis	ADHD/ADD	mumps
diabetes	high fever	lead exposure	cytomegalovirus
chronic colds	ear infections	asthma	chicken pox
pneumonia	encephalitis	tonsillitis	Lyme's disease
learning disability	hearing loss	spina bifida	stuttering
congenital birth defect	club foot	autism/PPD	voice problems
fear of loud noises	behavior issues	psychological issues	cerebral palsy

Does your child have any other medical conditions? Yes No

(If yes, please describe): _____

_____

Allergies: _____

Current medications: _____

_____

_____

Are immunizations up to date? Yes No

9. Is any language other than English spoken at home? Yes No

If yes, what language? _____

How often? _____

10. Please rate your child on the following: (1 - impaired / 5 - typical)

- Ability to be understood by others 1 2 3 4 5
- Ability to effectively express himself/herself 1 2 3 4 5
- Ability to understand what is said to him/her 1 2 3 4 5
- Ability to interact with peers 1 2 3 4 5
- Ability to play appropriately 1 2 3 4 5

SPEECH/LANGUAGE PATHOLOGY GENERAL HEALTH FORM - Page 3 of 4

Please elaborate on areas of weakness:

_____

_____

Does your child exhibit any frustration and/or challenging behaviors related to the inability to effectively communicate? (If yes, please describe) _____

_____

11. When did you first recognize the difficulty/problem? _____

_____

12. Is there a family history of the following:
    - Speech/language difficulties: Yes No
      (If yes, please describe) _____
      _____
    - Hearing difficulties Yes No
      (If yes, please describe) _____
      _____
    - Vision difficulties Yes No
      (If yes, please describe) _____
      _____

13. Has your child:
    - Ever participated in speech and language testing? Yes No
      (If yes) When? _____
      Where? _____
      With whom? _____
      Results? _____
    - Ever participated in speech and language therapy? Yes No
      (If yes) When? _____
      Where? _____
      With whom? _____
      Results? _____
      Goals: _____
      Reason for discontinuing services? _____
      _____
    - Ever had a feeding/swallowing medical evaluation? Yes No
      (If yes) When? _____
      Where? _____
      With whom? _____
      Results? _____
    - Ever had vision testing? Yes No
      (If yes) When? _____
      Where? _____
      With whom? _____
      Results? _____
    - Ever had audiological (hearing) testing? Yes No
      (If yes) When? _____
      Where? _____
      With whom? _____
      Results? _____

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PEDIATRIC SPEECH/LANGUAGE PATHOLOGY GENERAL HEALTH FORM

14. Do you have any concerns regarding your child's:

- Hearing difficulties Yes No
  (If yes, please describe) _____
- Vision difficulties Yes No
  (If yes, please describe) _____
- Feeding/Swallowing/Nutrition: Yes No
  If yes, please describe including diet, specialized equipment, eating patterns at home and school, etc.) _____

15. Screening for Abuse and Neglect:
    Do you suspect your child has been physically, sexually, or emotionally abused?
    ☐ Yes ☐ No

16. Where does your child attend school?
    School: _____ Grade: _____
    Teacher: _____ City/Town: _____

17. Has your child ever received special services at school? Yes No
    If yes, please list these and describe including dates and grades: _____

18. Does your child have any difficulties in school? Yes No
    (If yes, please describe) _____

19. What are your child's strengths in school? _____

20. What are you hoping to gain from this evaluation? _____

***Please attach any other information or comments that might be helpful along with any** reports/notes regarding your child's testing and/or previous therapy.*

Please sign below to confirm that:

a) The above information is accurate to the best of your knowledge.
b) You have been given a copy of the policies of Spaulding Rehabilitation Hospital – Cape Cod Outpatient Program (available at registration).
c) You agree to notify this facility with any changes to your child's status as a patient at Spaulding Rehabilitation Hospital – Cape Cod Outpatient Program.

Parent/Guardian Signature	Date	Time	Speech Language Pathologist Signature	Date	Time

Thank you so much for taking the time to fill out this form.
Your responses will help us know your child a lot better!