



Northeastern University

Department of Communication Sciences & Disorders
Speech-Language and Hearing Center
503 Behrakis Health Science Center
Boston, MA 02115
(617) 373-2492

SPEECH - LANGUAGE EVALUATION PEDIATRIC CLIENT APPLICATION FORM

(Ages birth – 18 years)

To be completed by parent/guardian and returned to the Center

TODAY'S DATE: _____

IDENTIFYING INFORMATION

Name of child to be evaluated:		Sex:
Home Address: Street: _____ City: _____ State: _____ Zip Code: _____		Phone: Home Work Cell _____ _____
Child's Date of Birth:	Age:	Grade:
Language Dominance:		
Other Languages Spoken:		
Who should be contacted to schedule an appointment:		Referred by:

Parent/Guardian Name:		
Home Address: check here if same as above: <input type="checkbox"/> Street: _____ City: _____ State: _____ Zip Code: _____		Phone: Home Work Cell _____ _____
Email:		
Date of Birth:	Age:	
Level of Education Completed:	Occupation:	

Parent/Guardian Name:		
Home Address: check here if same as above: <input type="checkbox"/> Street: _____ City: _____ State: _____ Zip Code: _____		Phone: Home Work Cell _____ _____
Email:		
Date of Birth:	Age:	
Level of Education Completed:	Occupation:	



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Names of Siblings:	Age:	Grade:	Learning/Speech Problems? <i>Y/N & indicate type</i>
			Y N
			Y N
			Y N
			Y N
Is there anyone else living in the home? If so, whom?			
Has there been a history of divorce or separation in this family? Y N			

REASON FOR REFERRAL/REQUEST:

Description of problem:	
1.	Please describe your child's speech or hearing difficulty.
2.	When and how did the problem begin?
3.	Who was the first person to notice the problem?
4.	Is your child aware of the problem?
5.	Describe any changes in the problem since it began.

HISTORY: PREGNANCY & BIRTH (of child to be evaluated, if known)

1. Please describe the health of the person who carried your child:	
Before pregnancy?	
During pregnancy?	
After pregnancy?	
2. Did the person who carried your child experience any of the following during pregnancy?	
	<i>Approximately when during pregnancy?</i>
<input type="checkbox"/>	German Measles
<input type="checkbox"/>	High Fever
<input type="checkbox"/>	Kidney Infection



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<input type="checkbox"/>	Anemia	
<input type="checkbox"/>	Bleeding	
<input type="checkbox"/>	Swelling legs and/or arms	
<input type="checkbox"/>	X-rays	
<input type="checkbox"/>	Accidents	
<input type="checkbox"/>	Drugs	
<input type="checkbox"/>	Other:	
3. Was your child <i>full term</i> or <i>premature</i>? (check one) <input type="checkbox"/> Full term <input type="checkbox"/> Premature If premature: How many weeks? _____ Birth Weight: _____		
4. Labor: <input type="checkbox"/> More than 10 hours <input type="checkbox"/> Difficult <input type="checkbox"/> Less than 2 hours <input type="checkbox"/> Don't know/don't recall		
5. Hospital where child was delivered:		
6. Attending physician:		
7. Delivery: <input type="checkbox"/> Normal <input type="checkbox"/> Cesarean <input type="checkbox"/> Breech <input type="checkbox"/> Forceps <input type="checkbox"/> Anesthesia <input type="checkbox"/> Other (describe)		
8. Was breathing difficult to initiate in your child? Y N		
9. Did your child present any of the following problems at birth?		
<input type="checkbox"/>	Bruises/abnormalities in the head region	<input type="checkbox"/> Need for oxygen
<input type="checkbox"/>	RH incompatibility	<input type="checkbox"/> Feeding problems
<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/> Blood transfusions
<input type="checkbox"/>	Cleft lip / palate	<input type="checkbox"/> Other (describe below):
<input type="checkbox"/>	Bruises/abnormalities in the head region	
<input type="checkbox"/>	RH incompatibility	
10. Did your child receive any special medication or treatment at birth?		
11. Is there any history of miscarriage or still birth?		

HISTORY: DEVELOPMENTAL MILESTONES

1. Please check if the infant: <input type="checkbox"/> Cried excessively <input type="checkbox"/> Resisted being held <input type="checkbox"/> Was responsive to affection	
2. Please indicate the approximate age when the following first occurred:	
_____ held head up	_____ first combined words
_____ sat up	_____ fed self with spoon
_____ crawled	_____ achieved bladder control



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_____ walked	_____ achieved bowel control
_____ first babbled	_____ stopped wetting at night
_____ said first words	
3. Does your child show hand preference? Y N If so: <input type="checkbox"/> right <input type="checkbox"/> left	
4. Do you feel that your child has any of the following traits? Describe:	
<input type="checkbox"/> highly active	
<input type="checkbox"/> eating problems	
<input type="checkbox"/> sleeping problems	
<input type="checkbox"/> toilet-training problems	
<input type="checkbox"/> problems playing with other children	
<input type="checkbox"/> discipline problem	
<input type="checkbox"/> unusual fears	
<input type="checkbox"/> nervous habits	
<input type="checkbox"/> strange behaviors that trouble you	
<input type="checkbox"/> awkwardness and lack of coordination	
<input type="checkbox"/> dental problems	
<input type="checkbox"/> bed wetting	
<input type="checkbox"/> other	

HEALTH RECORD:

1. Describe your child's general health.		
2. Is your child currently under medical treatment or medication?		
3. Who is your family physician or pediatrician?		
Name: _____	Address: _____	
Phone: _____	Street: _____	
	City: _____	
	State: _____	
	Zip Code: _____	
4. List and describe any hospitalization, operations, or accidents.		
5. Please indicate if your child has had any of the following:		
<input type="checkbox"/> mumps	<input type="checkbox"/> convulsions	<input type="checkbox"/> fainting spells
<input type="checkbox"/> measles	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> ear aches/infections
<input type="checkbox"/> chicken pox	<input type="checkbox"/> pneumonia	<input type="checkbox"/> allergies
<input type="checkbox"/> whooping cough	<input type="checkbox"/> frequent laryngitis	<input type="checkbox"/> meningitis
<input type="checkbox"/> scarlet fever	<input type="checkbox"/> tonsillitis	<input type="checkbox"/> freq. sore throat



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<input type="checkbox"/> High fever	<input type="checkbox"/> frequent colds	<input type="checkbox"/> other:
6. Does your child ever complain about hearing noises (ringing, buzzing, roaring, etc.) in the child's ears?		
7. Has your child been exposed to loud sounds (gunfire, heavy machinery, etc.)?		
8. Does anyone with biological ties to the child have a history of any of the following:		
Problem:	Relationship:	
<input type="checkbox"/> speech, language problems		
<input type="checkbox"/> hearing problems		
<input type="checkbox"/> brain damage		
<input type="checkbox"/> mental retardation		
<input type="checkbox"/> cerebral palsy		
<input type="checkbox"/> emotional disturbance/mental illness		
<input type="checkbox"/> chronic illness (Please Specify Type: _____)		

EDUCATIONAL HISTORY:

1. Level	Attended? (Check if 'yes')	Dates
Nursery school, Day-care	<input type="checkbox"/>	
Kindergarten	<input type="checkbox"/>	
1st grade	<input type="checkbox"/>	
2. Has your child repeated a grade? Y N If so, which one?		
3. Is your child in a special class?		
4. Is your child receiving tutoring in any subject area?		
5. Has your child been diagnosed with any conditions or disorders? If so, what are these diagnoses?		
6. What school does your child attend now?		
Name: _____	Street: _____	
Phone: _____	City: _____	
	State: _____	
Grade: _____	Zip Code: _____	
Principal's Name: _____		Teacher's Name: _____
7. What is your child's attitude toward school?		
8. What is your child's favorite school subject or activity?		
9. What subject / activity does the child complain about the most?		



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10. Please check any of the following that you feel are true of your child:			
<input type="checkbox"/>	discipline problem	<input type="checkbox"/>	receives preferential seating
<input type="checkbox"/>	difficulty learning to read	<input type="checkbox"/>	speech/hearing problem affects school work
<input type="checkbox"/>	difficulty learning to write	<input type="checkbox"/>	complains of being teased by classmates about the child's speech
<input type="checkbox"/>	short attention span		

SPEECH & LANGUAGE DEVELOPMENT:

1. At what age did your child first put words together meaningfully?			
2. Who was your child's primary speech model?			
3. Has your child been exposed to more than one language?			
4. Did your child stop talking or making sounds at some time? If so, at what age?			
5. Have you always had difficulty understanding what your child is saying?			
6. Which member of your household understands your child's speech the best?			
7. Who has the most difficulty understanding your child?			
8. Please check any of the following characteristics that are CURRENTLY true of your child's speech:			
<input type="checkbox"/>	out of breath while talking	<input type="checkbox"/>	uses gestures instead of words to communicate
<input type="checkbox"/>	drools while talking	<input type="checkbox"/>	uses single words only
<input type="checkbox"/>	overly tense while talking	<input type="checkbox"/>	always talks too softly
<input type="checkbox"/>	holds breath while talking	<input type="checkbox"/>	always talks too loudly
<input type="checkbox"/>	tries to talk faster than the child can think	<input type="checkbox"/>	doesn't talk, just makes grunting noises
<input type="checkbox"/>	more difficulty than others thinking what to say	<input type="checkbox"/>	seems to stare at people when they talk
<input type="checkbox"/>	hoarse voice	<input type="checkbox"/>	won't answer you if the child can't see you talk
<input type="checkbox"/>	abnormally high pitched voice	<input type="checkbox"/>	often refuses to talk to people
<input type="checkbox"/>	sounds like the child is talking through the nose		
9. Does your child....			
<input type="checkbox"/>	Hear when you call?		
<input type="checkbox"/>	Hear the telephone?		
<input type="checkbox"/>	Understand what you say?		
<input type="checkbox"/>	Follow simple commands or requests?		
10. Does your child usually ask for things by (please check one)...			
<input type="checkbox"/>	making sounds		



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<input type="checkbox"/>	using appropriate words		
<input type="checkbox"/>	using phrases or sentences		
<input type="checkbox"/>	pointing or gesturing		
<input type="checkbox"/>	getting a sibling to get it for the child		
11. Have you ever felt that your child had difficulty hearing? Yes No			
How old was your child when you first questioned your child's ability to hear?			
Has your child ever had a hearing test? Yes No			
	When?		
	Where?		
12. Does your child wear a hearing aid? Yes No			
Approximately when was it purchased? _____			
What is the make and model number? _____			
Who is your hearing aid dealer? _____			
	Address:		
Does this aid seem to be operating properly at this time? Yes No			
13. Has anything been done to improve your child's speech? Yes No			
If yes, what has been done? _____			
Did the speech appear to improve? Yes No			
14. Have you had your child evaluated by any other clinic? Yes No			
<u>Name of Clinic:</u>	<u>Address of Clinic:</u>	<u>Date of Evaluation:</u>	<u>Findings:</u>
15. Has your child received speech therapy previous to this time? Yes No			
<u>Place</u>	<u>Dates</u>	<u>Therapist</u>	



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PERMISSIONS/SCHEDULING:

May we have your permission to request information about the evaluation and/or therapy mentioned above to assist us in our evaluation of your present difficulty? Yes No
If so, please fill out one of the attached "AUTHORIZATION FOR RELEASE OF INFORMATION" forms. If the evaluation and therapy took place in more than one place, please fill out one form for each setting.

To whom would you wish our reports to be sent?

Name of person filling out this form:

Relationship to child:

Date form
completed:

Who suggested that you request an evaluation at Northeastern?

Name: _____ Position: _____

Are there any limitations on your schedule that would make it impossible for you to come for an evaluation on any specific day?

If you have any other information that you feel would be helpful to us in preparing for your evaluation, please write it in the space provided below.

Thank you for your time in filling out this form!

Please email your completed form to Sarah Young-Hong, s.younghong@northeastern.edu, or print and mail to:

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