Therapies 4 Kids
Exceptional Care For Exceptional Children

☐ **WESTON**
1495 North Park Drive
Weston, FL 33326

☐ **CORAL SPRINGS**
1750 N. University Drive
Suites 105-107-109
Coral Springs, FL 33071

☐ **BOCA RATON**
5970 SW 18th Street
Suites E6-E7
Boca Raton, FL 33433

☐ **PEMBROKE PINES**
1311-1321 N. Palm Avenue
Pembroke Pines, FL 33026

Phone: (954) 356 2878 • Fax: (954) 241 6726 • Email: info@therapies4kids.com • Website: www.t4k.com

SPEECH/LANGUAGE PATHOLOGY DEPARTMENT

Evaluation Date: ___ / ___ / _____ *(Mo./Day/Year)*

PATIENT'S INFORMATION

Patient's Name: _____ D.O.B: ___ / ___ / _____ *(Mo./Day/Year)* Age: _____ ☐ M ☐ F

Parent/Caregiver's Name: _____

Is the relationship biological? ☐ Yes ☐ No If No, please explain: _____

Primary Language Spoken at Home: _____ Secondary Language Spoken at Home: _____

Physician's Name: _____ Specialty: _____

PATIENT'S DIAGNOSIS

Please check only relevant diagnosis.

☐ ADD	☐ Cerebral Palsy	☐ Developmental Delay
☐ ADHD	☐ Down Syndrome	☐ Fragile X
☐ Autism (ASD)	☐ Traumatic Brain Injury	☐ Muscular Dystrophy
☐ Asperger Syndrome	☐ Fetal Alcohol Syndrome	☐ Obsessive Compulsive Disorder
☐ Tourette Syndrome	☐ Prematurity	☐ Oppositional Defiant Disorder
☐ Speech Delay	☐ Low Birth Weight	☐ Other Chromosomal Abnormalities
☐ Learning Disability	☐ Reading Disorder	☐ Wrtiting Disorder
☐ Stuttering	☐ Seizure Disorder*	☐ Apraxia of speech

(*) Seizure Disorder, if YES, are they under control? ☐ Yes ☐ No

Describe the symptoms / what precautions do we need to take? _____

Allergies? ☐ Yes ☐ No If Yes, please specify: _____

Medications? ☐ Yes ☐ No If Yes, please specify medications, dose and frequency:

MEDICATION NAME	PURPOSE	DOSE & FREQUENCY

MEDICAL HISTORY

Pre-Pregnancy, Pregnancy and Delivery Period

Were fertility drugs used? ☐ Yes ☐ No In Vitro fertilization? ☐ Yes ☐ No Length of Pregnancy: _____ *(in weeks)*

Is the child a twin? ☐ Yes ☐ No In case of twins is the other child well? ☐ Yes ☐ No _____ *(please specify)*

Were there any medical conditions issues prior to pregnancy which continued into pregnancy? ☐ Yes ☐ No

Were there any medical complications during pregnancy?

☐ Low blood pressure ☐ High blood pressure ☐ UTI ☐ Kidney problems ☐ Preeclampsia

☐ Gestational Diabetes ☐ Sepsis ☐ Placenta detachment ☐ Other _____ *(please specify)*

Were medications taken during the pregnancy? ☐ Yes ☐ No For condition: _____ *(please specify)*

Was alcohol consumed during the pregnancy? ☐ Yes ☐ No

Did any problems arise during fetal development? ☐ Yes ☐ No Please explain: _____

Were there any complications during labor? ☐ Yes ☐ No Please explain: _____

Labor/Birth occurred at: ☐ Home ☐ Hospital ☐ Other _____ *(please specify)*

Type of delivery: ☐ Vaginal ☐ Induced ☐ Planned C-Section ☐ Emergency C-Section

Immediately After Birth

Child's Birth Weight: _____ *(Lbs, Oz)*

Was child suctioned immediately after delivery? ☐ Yes ☐ No Reason: _____

Did the child (swallow) aspirate Meconium? ☐ Yes ☐ No

Was child placed on oxygen? ☐ Yes ☐ No How long? _____ *(days)*

Was child placed on respirator? ☐ Yes ☐ No How long? _____ *(days)*

Was child placed on NICU? ☐ Yes ☐ No How long? _____ *(days)*

Specify any procedure:

☐ Swallow studies ☐ Shunt Placement ☐ Visual Testing ☐ Surgeries* ☐ Cardiac Intervention

☐ NG/G Tube placement ☐ MRI/ CAT Scan ☐ Lung intervention ☐ EEG ☐ Hearing Assessment

(*) If YES to Surgeries please explain: _____

Early Months Feeding / Swallowing

Did baby breast feed? ☐ Yes ☐ No Did baby bottle feed? ☐ Yes ☐ No

Did baby have a difficulty latching onto the nipple? ☐ Yes ☐ No Latching onto the bottle? ☐ Yes ☐ No

Did the child experience reflux? ☐ Yes ☐ No If yes was medication prescribed? ☐ Yes ☐ No _____ *(please specify)*

Did child gag during feedings? ☐ Yes ☐ No Vomit? ☐ Yes ☐ No Spit out food? ☐ Yes ☐ No Cough? ☐ Yes ☐ No

Stick out their tongue when eating/drinking? ☐ Yes ☐ No Did milk/food spill out of mouth? ☐ Yes ☐ No

Did child refuse to eat? ☐ Yes ☐ No Did anyone every say that your child aspirated food/liquid at anytime*? ☐ Yes ☐ No

(*) If YES, please explain: _____

DEVELOPMENTAL MILESTONES

These questions cover the child's growth and development since their first year of life to the present.

Motor Control

Were developmental milestones achieved or delayed?

Rolling: ☐ Yes ☐ No Age: _____ **Sitting:** ☐ Yes ☐ No Age: _____ **Standing:** ☐ Yes ☐ No Age: _____

Crawling: ☐ Yes ☐ No Age: _____ **Walking:** ☐ Yes ☐ No Age: _____

Hearing

Did the child have frequent colds? ☐ Yes ☐ No Ear infections? ☐ Yes ☐ No Ear tubes? ☐ Yes ☐ No

If yes, how often? _____ At what age(s) did the child receive the tubes? _____ Are tubes still in place? ☐ Yes ☐ No

Was a hearing test REPEATED? ☐ Yes ☐ No Age(s): _____

Is there a diagnosed Hearing Impairment? ☐ Yes ☐ No _____ *(please specify)*

Does the child wear Hearing Aids or have Cochlear Implants? ☐ Yes ☐ No _____ *(please specify)*

Vision

Visual Problems? ☐ Yes ☐ No If yes, what is the diagnosis? _____

Owns prescription glasses? ☐ Yes ☐ No Are glasses worn? ☐ Yes ☐ No

Sleep Disturbances

Does child sleep well at night? ☐ Yes ☐ No If no, please describe problem/behavior: _____

_____

Toilet training

Is child toilet trained? ☐ Yes ☐ No If not entirely, please explain: _____

_____

SWALLOWING - EATING - DRINKING - PICKY EATERS

Swallowing and feeding problems come in various forms. Please share with us any problems listed below that you have observed with your child during mealtimes.

Feeding Behaviors and Problems to Resolve

TYPICAL FEEDING PROBLEM	ALWAYS	OFTEN	SOMETIMES	NEVER
Coughing while eating				
Coughing while drinking/eating				
Aspirations/"colds" while drinking/eating				
Drooling				
Nasal discharge while eating/during eating				
Frequent sneezing				
Food drink spillage from mouth				

Diet

Is your child on a special diet? ☐ Yes ☐ No If yes, be specific: _____

_____

Is your child a picky eater? ☐ Yes ☐ No If yes, please list the foods your child will eat: _____

_____

Do foods have to taste identically every time or be purchased from the same restaurant? ☐ Yes ☐ No

List foods your child dislikes: _____

How are these aversions demonstrated? _____

Do food reinforces work for your child? ☐ Yes ☐ No What kinds? _____

FOLLOW-UP TESTS

Since 2 years of age.

- ☐ CT Scan
- ☐ MRI
- ☐ X-Rays
- ☐ EEG
- ☐ Swallow Study
- ☐ Feeding Assessment
- ☐ ABA Evaluation
- ☐ Psychological Testing
- ☐ Physical Therapy Evaluation
- ☐ Speech Evaluation
- ☐ Occupational Therapy Evaluation

Were there any significant findings of these tests? Please explain: _____

_____

Has your child received previous therapy services? ☐ Yes ☐ No

Please provide details of when and where your child received therapy: _____

Is child still receiving therapy? ☐ Yes ☐ No If yes, please explain: _____

FAMILY BACKGROUND

Who lives with the child right now? _____

Are both parents in the life of the child? _____

If the parents do not live together what is the living arrangement for the referred child? _____

_____

Are there other siblings? ☐ Yes ☐ No Ages: _____

Do the other children have any problems? ☐ Yes ☐ No If yes please specify: _____

Genetics is no one's control. Problems exist in most, if not all families. Family members who struggle with similar problems can provide invaluable insight into their child that can help us in the treatment process. So please: If there is anybody else in the family who is showing signs or was diagnosed with any of the conditions listed below please check any of the appropriate areas.

- ☐ Autism (ASD)
- ☐ ADHD
- ☐ ADD
- ☐ Learning Disability
- ☐ Delayed Speech
- ☐ Asperger Syndrome
- ☐ Depression
- ☐ Bi-polar (Manic Depressive) Disorder
- ☐ Oppositional Defiance Disorder
- ☐ Schizophrenia
- ☐ Stuttering
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Hearing Problems
- ☐ Apraxia of Speech

If yes, please indicate on which side of the family these issues were found:

☐ Mother ☐ Father ☐ Both

BEHAVIOR

Do you believe that your child has behavioral problems? ☐ Yes ☐ No ☐ Not sure

If yes, do you consider them to be: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

INAPPROPRIATE BEHAVIORS	**FREQUENCY** *(# of times)*	**AVERAGE DURATION** *(in minutes or hours)*
Per Week		
Per Day		

What percentage of the time does the child require supervision? _____ %

What is the typical level of supervision intensity? ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** From 0=no intensity to 5=extreme intensity.

Are there triggers that prompt the behavioral changes? ☐ Yes ☐ No Please explain: _____

_____

_____

ATTENTION & CONCENTRATION SKILLS

In this section we would like to know the level of your child's attention and concentration skills. This will help us structure our testing procedures as well as our care of plan.

YES/NO QUESTIONS	
1. Does your child need a calm, quiet environment in order to stay focused?	☐ Yes ☐ No
2. Does your child have difficulties paying attention to detail?	☐ Yes ☐ No
3. Does your child make careless mistakes?	☐ Yes ☐ No
4. Does child appear not to listen when spoken to?	☐ Yes ☐ No
5. Does your child have difficulty remembering things, following instructions?	☐ Yes ☐ No
6. Does your child have trouble staying organized, planning ahead, and finishing projects?	☐ Yes ☐ No
7. Does your child get bored with a task before it is completed?	☐ Yes ☐ No
8. Does your child frequently lose or misplace homework, books, toys, or other items?	☐ Yes ☐ No
9. Does your child have a hard time concentrating on structured repetitive or boring tasks but be able to concentrate for a long time on activities of great interest?	☐ Yes ☐ No

FREQUENCY QUESTIONS	
1. Does your child like to climb on high objects without regard to safety?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
2. Does your child like to spin?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
3. Does your child like to lie on the floor?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
4. Does your child run around from one side of the room to the other repeatedly?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
5. Does your child respond when you call his/her name?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
6. Does your child become easily distracted?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
7. Does your child like to align objects in a row?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
8. Does your child prefer to play with objects over people?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
9. Does your child make frequent flapping movements with his hands which do not appear to be related to a specific activity?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
10. Does your child look at rotating items over and over again?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
11. Does your child look at items at a very close range?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
12. Does your child rock in his chair or while standing?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
13. Does your child have temper tantrums? a) How frequently during the day? _____ b) For how long could these temper tantrums last? _____ c) What do you do to stop the tantrums? _____	☐ Always ☐ Usually ☐ Sometimes ☐ Never
13. Does your child sleep well at night?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
14. Do you consider your child to be defiant?	☐ Always ☐ Usually ☐ Sometimes ☐ Never
15. Does your child hit you?	☐ Always ☐ Usually ☐ Sometimes ☐ Never

Thank You for filling out this questionnaire!

The Therapies 4 Kids Staff