

Child lives with: () Birth Parents () Adoptive Parents () Other: _____
Parents are: () Married () Separated () Divorced () Other: _____
If your child was adopted, at which age and from where:

Please list other children in the family:

Name Age Relationship

General Questions:

Identify 3 to 5 key questions or concerns you would like addressed in this evaluation:

Describe your concerns about your child's development (including social interaction, communication, play, language and behavior).

Developmental History

If known, indicate at what age your child first performed the following (If skill has not yet been acquired, place an X on the line):

Babbled_____	Rolled Over_____
Used Single Words_____	Crawled_____
Began Combining Words_____	Sat Alone_____
Spoke in Short Sentences_____	Stood Alone_____
Ate Table Foods_____	Walked Independently_____
Fed Self_____	Grasped a Crayon_____
Toilet Trained_____	Dressed Self_____

Has your child ever gained skills and then lost them in any developmental area (i.e. language, toileting, motor skills?) () Yes () No

If yes, please explain: _____

Does your child choke on foods or liquids? () Yes () No
 Does your child currently put toys/objects in his/her mouth? () Yes () No
 Does your child brush his/her teeth and/or allow brushing? () Yes () No
 Is your child a picky eater? () Yes () No
 If yes, please describe any aversions to textures, temperatures, etc. _____

Behavioral characteristics your child demonstrates (Check all that apply):

- | | |
|-----------------------------------|-----------------------------------|
| () Cooperative/attentive | () Craves touch |
| () Willing to try new activities | () Poor eye contact |
| () Usually happy/easy going | () Repetitive behavior |
| () Plays/shares well with others | () Short attention span/restless |
| () Shy/quiet | () Tires easily |
| () Easily Frustrated | () Destructive/aggressive |
| () Impulsive/distractible | () Withdrawn |
| () Stubborn/resistant to change | () Self-abusive behavior |
| () Avoids Touch | () Other: _____ |

Information on Challenging Behaviors:

How frequently does your child display each of the following?

Target Behavior	Daily	Weekly	Monthly	N/A
Crying/Screaming				
Tantrums				
Aggressive Behaviors				
Please Describe (e.g., kicks, pinches, etc.):				
Self-Injurious Behaviors				
Please Describe (e.g., hits head, bites self, etc.):				
Property Destruction				
Please Describe (e.g., throws objects, rips materials, etc.):				

Has your child ever had a behavior plan to address challenging behaviors? () Yes () No

If yes, please include a copy of your child's behavior plan.

Does your child have difficulty with any of the following?

- | | | |
|--|---------|--------|
| Leaving preferred items/activities | () Yes | () No |
| Waiting or accepting no | () Yes | () No |
| Transitioning to less preferred activities | () Yes | () No |
| Completing instructional tasks? | () Yes | () No |

Does your child engage in repetitive or self-stimulatory behaviors that interfere with instruction and/or social activities? () Yes () No

Does your child engage in obsessive-compulsive behaviors that interfere with instruction and/or social activities? () Yes () No

Please explain any additional concern(s) you may have about your child's challenging behaviors: _____

Social Interaction

Does your child interact with other children? () Yes () No

Describe how your child interacts with other children _____

Does your child interact with adults? () Yes () No

Describe how your child interacts with adults: _____

Play

Does your child prefer to play alone? () Yes () No

What games and toys does your child prefer? _____

Describe how your child plays with toys: _____

Does your child play with other children? () Yes () No

If yes, describe how your child plays with other children: _____

Communication

Circle all statements that describe your child's communicative behavior:

- | | |
|--|---|
| a. Has not yet started to talk | i. Speech is too loud or too soft (<u>underline which</u>) |
| b. Was late in starting to talk | j. Pitch level is unusual (e.g., too high, too low) |
| c. Does not talk very much | k. Hesitates or repeats sounds and words excessively |
| d. Uses a lot of gestures | l. Can understand what you are saying |
| e. People have trouble understanding the child | m. Able to retrieve common objects upon request |
| f. Is not making speech sounds correctly
(That are expected for age) | n. Is able to follow simple directions |
| g. Tries hard and seems to want to
communicate | o. Asks questions of others |
| h. Has an unusual voice quality (hoarse, harsh, whispery) | p. Responds correctly to "wh" questions |

If there is any further information regarding communicative behavior or elaboration on the above statements can be included here: _____

Does your child have a means to indicate "yes" or "no"? If yes, please describe: _____

Do you think your child can understand more than they can say? () Yes () No
If yes, please explain or give an example: _____

Do you think your child gets frustrated when he or she cannot communicate effectively? () Yes () No

If yes, please explain or give an example: _____

Please mark the statement(s) that would best describe your child's current means of communication:

- () Crying or tantrums
- () Body language (e.g., pointing, looking, gesturing)
- () Sign Language
- () Pictures
- () Augmentative device (please describe): _____
- () Sounds (e.g., vowel sounds, consonant sounds, grunting)
- () Single words- please list several words used regularly _____
- () 2-4 word sentences- please provide example (s): _____

() Sentences longer than 4 words- please provide example (s): _____

() Other: _____

Does your child use their communication to (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> initiate communicative interaction | <input type="checkbox"/> Ask questions |
| <input type="checkbox"/> Comment on the past | <input type="checkbox"/> Reject non-preferred items |
| <input type="checkbox"/> Comment on the present | <input type="checkbox"/> Request people |
| <input type="checkbox"/> Comment on the future | <input type="checkbox"/> Request activities |
| <input type="checkbox"/> Respond to questions | <input type="checkbox"/> Request objects |

Has your child's communication ever been evaluated by a Licensed Speech Language Pathologist? Yes No

If your child has recently been evaluated, **please include a recent evaluation report** and summarize the results of the speech and language evaluation in terms of language comprehension, language production and speech production (how he produces his/her sounds): _____

Birth History

Was there anything unusual about the pregnancy or birth? Yes No
 If yes, please describe: _____

Was the mother ill during the pregnancy? Yes No
 If yes, please describe: _____

Did the mother take any medications during the pregnancy? Yes No
 If yes, please describe: _____

Was the pregnancy full term? Yes No
 If no, how many weeks was the pregnancy? _____

Delivery was: Vaginal Planned cesarean Emergency Cesarean Breach

Was your child hospitalized after birth? Yes No
 If yes, for what and how long? _____

Birth weight: _____ Length: _____ APGAR scores: _____

Is there any other information about the mother or baby that may be pertinent? _____

Medical History

Has your child had any of the following? (Check all that apply):

<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Head injury	<input type="checkbox"/> Sleeping difficulties
<input type="checkbox"/> Breathing difficulties/Asthma	<input type="checkbox"/> High Fevers	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Seizures	<input type="checkbox"/> Other: _____	

Ear Infections - How often/many: _____

Ear Tubes - When? _____

Other serious injuries/surgeries _____

Please list in detail all known allergies (include food, animal, plants/other): _____

Please list any medications your child takes regularly and for what reason: _____

Has your child received Genetic Testing? Yes No
If yes, please include a copy of the Genetic testing reports.

Has your child been evaluated by a psychologist for IQ Testing? Yes No
If yes, please include a copy of IQ Evaluation.

Is your child currently on a Gluten Free-Casein Free Diet? Yes No
Are there any other food restrictions? Yes No
If yes, please list: _____

Are there any precautions/medical restrictions that should be taken with your child? (e.g., food allergies, aggressive behavior, decreased awareness of safety, etc.) _____

Please describe any pertinent family medical history (i.e., mother, father, siblings, grandparents, etc): _____

Hearing and Vision

Have you ever questioned your child's ability to hear normally? Yes No
If yes, please explain: _____

Has your child ever had his or her hearing tested? Yes No
If yes, please describe the results: _____

Have you ever questioned your child's ability to see normally? Yes No
Has your child's vision been tested? Yes No

If yes, please describe the results: _____

Please include a copy of all Audiology and Vision evaluation reports.

Services:

What services does your child currently receive?

Service Provider (i.e., Speech-Language Pathologist, Occupational Therapist)	Frequency (i.e. Twice a week)	General Goals (i.e., increase vocabulary, increase fine motor skills, increase articulation)

If your child receives services, please include a recent treatment plan.

Educational Information:

Please complete for children in school:

Child's Present School: _____ Grade: _____

Please describe your child's classroom performance or participation in the classroom (if appropriate): _____

What are your child's strengths and/or best subjects? _____

Is your child receiving specialized/additional services through the school? Yes No
If yes, please explain: _____

If your child has an IFSP/IEP in place, please include a copy.

Thank you for taking the time to complete this form. Please address any additional concerns or comments below:
