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PEDIATRIC SPEECH-LANGUAGE PATHOLOGIST
Empowering children to reach their highest potential

Patient Information

Child's Name: _____ **Birthdate: _____**

Mother's Name: _____ **Best Phone: _____**

Email: _____

Father's Name: _____ **Best Phone: _____**

Email: _____

Address: _____

Physician: _____ **Phone: _____**

Current School: _____

Other Children in the family: _____

Any medical diagnosed illness or conditions? _____

Any allergies? _____
Any seizures? _____
Is your child taking any medications? _____

Are there or have there ever been any feeding problems? _____
_____
_____
_____

Has your child had any surgeries, accidents or hospitalizations? _____

Is your child aware of, or frustrated by, any speech/language difficulties? _____

_____

_____

What do you see as your child's most difficult problem in the home?

_____

_____

_____

_____

_____

What do you see as your child's strengths?

_____

_____

_____

_____

Is your child receiving any other current therapies (circle) Yes No

If yes, please list with what professionals: _____

_____

_____

Describe any behavioral issues your child may exhibit

_____

_____

_____

_____

_____

What are some of your child's interests/likes?

_____

_____

_____

_____

Please be sure to bring copies of any evaluations, treatment plans, or IEPs, etc