The Madison Center requests this information for the purpose of completing a thorough evaluation with your child. Depending on your child’s abilities, some questions may not be applicable.

general information:

/ / M / F

Patient’s Name D.O.B Age Gender

Person Providing Information Date

Who referred you to The Madison Center?

 Reason for referral?

 Reason for referral, cont.

Patient medical diagnoses

Is there any known history of the following in the immediate or extended family?

 Autism/PDD  ADHD  Learning Disabilities

 Hearing Loss  Stuttering  Speech/Language Delays

1. When did you first have concerns about your child?
2. What made you concerned?
3. What strategies or techniques have you been trying independently?
4. What specific skills would you like your child to achieve in therapy?

pregnancy and birth history:

1. Were there any illnesses, injury, bleeding, or other complications during your pregnancy?
2. Was your pregnancy full term? If not, please give gestational age.
3. Was labor and delivery normal?
4. Circle all that apply to your child’s delivery:

vaginal breech cesarean forceps suction oxygen respiratory assistance

Any comments:

1. Did you experience any complications with feeding? Yes / No *(If yes, please explain)*
2. How was your child fed as an infant and until what age? Bottle / Breast Age:
3. Please list any concerns regarding your child’s eating habits.

medical history:

1. Has your child experienced any of the following? *(Please check all that apply.)*

|  |  |  |
| --- | --- | --- |
| Chicken Pox |  Seizures |  Frequent ear infections or fluid in the ears. |
| Cleft Palate/Lip |  Gastroesophageal Reflux |  PE Tubes *(If so, when?)* |
| Vision Problems |  Feeding Tube | / / |

1. Is your child currently taking any medications? *(If yes, please list.)*
2. Does your child have any known food allergies? *(If yes, please list.)*
3. Has your child’s hearing been evaluated recently? *(If yes, when, by whom and what were the results?)*

/ /

Are there any other precautions we should know about that are not described above?

speech/language development:

1. What is your child’s primary mode of communication (gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange)?
2. If your child is talking, please indicate at what age your child began to:  Babble  2-3 word phrases

 First Word  Use language as primary mode of communication

1. Please give an estimate of how many words are in your child’s vocabulary.

Receptive (words understood) Expressive (words spoken)

1. How much of your child’s speech do you understand?

 10% or less  11-24%  25-50%  51-74%  75-100%

1. How much of your child’s speech do others understand?

 10% or less  11-24%  25-50%  51-74%  75-100%

1. Does your child demonstrate frustration when he/she is not understood? Yes / No *(Please explain.)*
2. Does your child demonstrate difficulty completing long term school projects due to difficulty of organizational skills, sequencing, self-monitoring and/or time management?

play and social skills:

1. Does your child engage in eye contact during communication? Yes / No / Sometimes
2. When given a choice, does your child prefer to play alone or with others? Alone / Others
3. Identify your child’s playmates and ages (identify which are siblings)?
4. Does your child:

Answer questions logically? Yes / No / Sometimes

Engage in turn taking? Yes / No / Sometimes

Initiate conversation? Yes / No / Sometimes

Maintain a topic? Yes / No / Sometimes

Recall & tell about every day events? Yes / No / Sometimes

Follow one-step directions? Yes / No / Sometimes

Greet people arriving or leaving? Yes / No / Sometimes

1. What are some of your child’s favorite toys/interests?
2. Does your child tend to be inflexible with other’s ideas?
3. Does your child have difficulty joining and participating in groups?
4. Does your child seem socially aggressive, shy or awkward?

developmental history:

1. When did your child begin to:

Roll independently (circle): (3-4 months) (5-6 months) (7-9 months) (9-11 months) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sit independently (circle): (3-4 months) (5-6 months) (7-9 months) (9-11 months) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crawl (circle): (6-8 months) (9-11 months) (12-14 months) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walk (circle): (9-11 months) (12-15 months) (16-19 months) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink from a sip cup independently (circle): (9-11 months) (12-16 months) (17-20 months) Other: \_\_\_\_\_\_\_\_\_\_\_\_

Feed self with utensils independently (circle): (2-2.4 years) (2.5-3 years) (3.1-3.5 years) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

1. Daily living skills: Please place an “x” indicating how much assistance your child requires to complete the

following hygiene activities.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Hygiene** | **Indepen-****dent** | **Supervision, while child completes independently** | **Assistance to set up, then completes independently** | **Requires some assistance** | **Requires a lot of assistance** | **Is totally dependent on others** | **Comments:** |
| **Toileting** |  |  |  |  |  |  |  |
| **Washing hands** |  |  |  |  |  |  |  |
| **Washing face** |  |  |  |  |  |  |  |
| **Taking a bath** |  |  |  |  |  |  |  |
| **Taking a shower** |  |  |  |  |  |  |  |
| **Wiping nose** |  |  |  |  |  |  |  |
| **Brushing teeth** |  |  |  |  |  |  |  |
| **Brushing hair** |  |  |  |  |  |  |  |
| **Finger and toenail clipping** |  |  |  |  |  |  |  |

 developmental history (cont):

1. Does your child bathe or shower? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much help is required and for what tasks?
2. How much help does your child require for tooth brushing?
3. How does your child handle haircuts?
4. Does your child fall asleep right away or take a while?
5. How is your child’s quality of sleep?
6. Does your child have any clothing sensitivities (e.g. tags, pants, hats, certain fabrics)?
7. Is your child a picky eater? \_\_\_\_\_\_\_\_\_\_\_ Does your child avoid certain food textures or temperatures (e.g. cottage cheese, soups, pasta with sauces, yogurt with fruit chunks)? If so, which ones?
8. Does your child sit through meal times or does s/he get up and wander? Is the family able to eat out at restaurants?
9. What is your child’s favorite thing to do at the park or at recess (e.g. swing, slide, climb, run)?
10. Is your child safe playing, or does s/he take excessive risks?
11. What are your child’s arousal levels throughout the day (e.g. always bouncing off the wall, periods of calm, frequently under aroused or appear sleepy)?
12. How does homework time or reading a book go with your child?

 education:

1. Does your child attend school? If yes, where and how often?
2. What grade is your child presently in?

*Thank you for taking the time to complete this form.*

1. Please list any services your child receives at school (speech, occupational therapy, physical therapy, tutoring, etc.) and frequency.
2. Please list any services your child receives outside of school (speech, occupational therapy, physical therapy, tutoring, etc.) and frequency.
3. Is your child on an Individualized Education Plan (IEP) or 504 plan? Please list services or modifications.
4. May we communicate with the school therapists to collaborate services? Yes / No

*(If yes, please list their information on the “Consent for Release” form and provide a copy of your child’s most current IEP.)*

1. Does your child experience any specific challenges in school? *(Please explain.)*