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: ☐ 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: ☐ 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? *Y/N & indicate type*
			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?		
		Approximately when during pregnancy?
☐	German Measles	
☐	High Fever	
☐	Kidney Infection	

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☐	Anemia	
☐	Bleeding	
☐	Swelling legs and/or arms	
☐	X-rays	
☐	Accidents	
☐	Drugs	
☐	Other:	

3. Was your child *full term* or *premature*? (check one) ☐ Full term ☐ Premature
If premature: How many weeks? Birth Weight:

4. Labor:
☐ More than 10 hours ☐ Difficult
☐ Less than 2 hours ☐ Don't know/don't recall

5. Hospital where child was delivered:

6. Attending physician:

7. Delivery:
☐ Normal ☐ Cesarean ☐ Breech
☐ Forceps ☐ Anesthesia ☐ 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?

☐	Bruises/abnormalities in the head region	☐	Need for oxygen
☐	RH incompatibility	☐	Feeding problems
☐	Cerebral Palsy	☐	Blood transfusions
☐	Cleft lip / palate	☐	Other (describe below):
☐	Bruises/abnormalities in the head region		
☐	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: ☐ Cried excessively ☐ Resisted being held ☐ 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**: ☐ right ☐ left

4. Do you feel that your child has any of the following traits? **Describe:**

☐	highly active	
☐	eating problems	
☐	sleeping problems	
☐	toilet-training problems	
☐	problems playing with other children	
☐	discipline problem	
☐	unusual fears	
☐	nervous habits	
☐	strange behaviors that trouble you	
☐	awkwardness and lack of coordination	
☐	dental problems	
☐	bed wetting	
☐	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:

☐ mumps	☐ convulsions	☐ fainting spells
☐ measles	☐ tuberculosis	☐ ear aches/infections
☐ chicken pox	☐ pneumonia	☐ allergies
☐ whooping cough	☐ frequent laryngitis	☐ meningitis
☐ scarlet fever	☐ tonsillitis	☐ freq. sore throat

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☐ High fever	☐ frequent colds	☐ 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:**	
☐ speech, language problems		
☐ hearing problems		
☐ brain damage		
☐ mental retardation		
☐ cerebral palsy		
☐ emotional disturbance/mental illness		
☐ chronic illness (Please Specify Type:_____)		

EDUCATIONAL HISTORY:

1. Level	**Attended? (Check if 'yes')**	**Dates**
Nursery school, Day-care	☐	
Kindergarten	☐	
1st grade	☐	
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:			
☐	discipline problem	☐	receives preferential seating
☐	difficulty learning to read	☐	speech/hearing problem affects school work
☐	difficulty learning to write	☐	complains of being teased by classmates about the child's speech
☐	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:			
☐	out of breath while talking	☐	uses gestures instead of words to communicate
☐	drools while talking	☐	uses single words only
☐	overly tense while talking	☐	always talks too softly
☐	holds breath while talking	☐	always talks too loudly
☐	tries to talk faster than the child can think	☐	doesn't talk, just makes grunting noises
☐	more difficulty than others thinking what to say	☐	seems to stare at people when they talk
☐	hoarse voice	☐	won't answer you if the child can't see you talk
☐	abnormally high pitched voice	☐	often refuses to talk to people
☐	sounds like the child is talking through the nose		
9. Does your child….			
☐	Hear when you call?		
☐	Hear the telephone?		
☐	Understand what you say?		
☐	Follow simple commands or requests?		
10. Does your child usually ask for things by (please check one)…			
☐	making sounds		

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☐	using appropriate words
☐	using phrases or sentences
☐	pointing or gesturing
☐	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

Name of Clinic:	**Address of Clinic:**	**Date of Evaluation:**	**Findings:**

15. Has your child received speech therapy previous to this time? Yes No

Place	**Dates**	**Therapist**

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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 SLHC@northeastern.edu, or print and mail to:

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