Madison Speech, LLC

Registration Form

NOTE: Please complete this paperwork as accurately as possible. The information provided is kept confidential.

Date of Evaluation: ____ / ____ / ________

Patient Information:

Name: ______________________ ____________________ ____ Preferred Name: __________________
(Last) (First) (Middle Initial)

Date of Birth: ____ / ____ / _________ Age: ______ Gender: Male / Female

Address: ____
(Street) (City) (State) (Zip)
Primary Language Spoken: ______________________ Secondary Language Spoken: ______________________

Parent/Guardian Information: (If child is a minor)

Mother: ___________________________ **Legal Guardian: Yes No** Date of Birth: ____ / ____ / ______
Address: ____
Phone: (cell): ____________________ (work): ____________________
Email address: _______________________________________ Employer/Occupation: _______________________

Father: ___________________________ **Legal Guardian: Yes No** Date of Birth: ____ / ____ / ______
Address (*If different from above*): ____
Phone (cell): ____________________ (work): ____________________
Email address: _______________________________________ Employer/Occupation: _______________________

Insurance Information:
Primary Insurance: ____________________________________ Policy #: ______________________________
Subscriber's name: ____________________________________ Subscriber's DOB: ____ / ____ / ______
Patient's relationship to subscriber (please circle): *self* *spouse* *child* *other*______________

Secondary insurance: __________________________________ Policy #: ______________________________
Subscriber's name: ____________________________________ Subscriber's DOB: ____ / ____ / ______
Patient's relationship to subscriber (please circle): *self* *spouse* *child* *other*______________

Emergency Contacts: (Other than parents listed above)

Name: _____________________________________ Relationship: _________________ Phone: __________________

Name: _____________________________________ Relationship: _________________ Phone: __________________

Referral Information:
Primary Care Physician: ____
Referred by: *Doctor/Pediatrician* *Self* *Other*: _________________________________

Pregnancy/Birth History:
Length of pregnancy: ____________________ Mother's age during pregnancy: _________________
Birth weight of child: ________lbs. ________oz. Type of delivery (please circle): Caesarian / Vaginal
Length of Labor: _____________________ **N/A**
Please list any complications and/or prescribed medications during pregnancy, labor, or delivery:
____
____
Were drugs or alcohol used during pregnancy? **Yes** **No**
Did your child experience any health problems during or after birth? **Yes** **No**
If **yes**, please provide details. ____
____
Number of days spent in the hospital/NICU: ____________________________

Hearing and Vision:
Most recent hearing screening: _____________________ Most recent vision check: _________________
Does the patient wear hearing aids? **Yes** **No** Does the patient wear glasses? **Yes** **No**
Does the patient have a history of ear infections? **Yes** **No** PE (Ear) Tubes? **Yes** **No**

Medical History:
Current medical diagnoses: ____
____
____
Surgeries (e.g., Tonsillectomy, Frenectomy, PE tubes, cleft palate repair, etc.): *Please include dates*.
____
____
Current Medications: ____
____
Please list any allergies the patient may have (including food allergies): ______________________
____

Education:
My child attends: *Preschool/Daycare* *Elementary* *Middle* *High* *NONE*
Is your child on an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)? **Yes** **No**
**If yes, please provide a copy to our office*.
Please list any special education services or accommodations received in school. ___________________
____
Describe any concerns noted by the teacher (e.g., peer interactions, following directions, reading, writing, spelling): ____
____

Developmental & Speech/Language Milestones:

Were all gross motor & fine motor skills met on time (e.g., *sitting, crawling, walking, self-feeding*)? **Yes** **No**

If **no**, please describe. ______________________________

____

Do you have any sensory concerns (e.g., *lights, sounds, textures, touch, etc.*)? **Yes** **No**

If **yes**, please describe. ______________________________

____

Please list any ***therapy services/evaluations/diagnoses*** that your child has received to date (e.g., *Physical therapy, Occupational therapy, Behavioral therapy, Play therapy, Early Intervention, Dyslexia, Learning disability, genetic testing, developmental testing*) ______________________________

____

____

Please list your primary concerns regarding your child's speech/language skills: ______________________________

____

Is there an immediate family history of any speech/language/stuttering disorders? **Yes** **No**

If **yes**, please explain. ______________________________

Did your child babble or make cooing sounds as an infant? **Yes** **No**

My child's speech is best described as:

O **NO WORDS** O **WORD APPROXIMATIONS** ("bah-bah" for "bottle") O **SINGLE WORDS** ("ball")

O **TWO WORDS** ("Bye mommy") O **THREE WORDS** ("That my car") O **FOUR + WORDS**

Approximately how much of your child's speech do **you** understand?

_____less than 10% _____25% _____50% _____75% _____90-100%

Approximately how much of your child's speech do those **less familiar** with your child understand?

_____less than 10% _____25% _____50% _____75% _____90-100%

MILESTONE	AGE	N/A	COMMENTS
Said first words			
Followed simple 1-step directions			
Potty Trained			
Weaned from bottle/breast			* If breastfed, did the patient have difficulty latching? **Yes** **No**
Weaned from pacifier			
Does your child suck their thumb/fingers?	Yes	No	

Communication goals:

Please list any goals you wish to achieve in regards to your child's communication skills.

____

____

____