Madison Speech, LLC

Registration Form

Please complete this form 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:

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

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

Pregnancy/Birth History: (For patients under age 6)
Length of pregnancy: _____ Mother's age during pregnancy: _____
Birth weight of child: _____ Type of delivery (please circle): Caesarian / Vaginal
Length of Labor: _____
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**

Medical History:
Current medical diagnoses: _____
_____
_____
Surgeries/Operations (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 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, Early Intervention, Dyslexia, Learning disability, Developmental testing, Genetic testing*, etc.) _____
_____
_____

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** ("bay" for "baby") O **Single word utterances** ("Hi")

O **Two-word phrases** ("Bye mommy") O **Three-word phrases** ("That my car") O **4+ word phrases**

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.
_____
_____
_____