



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: \_\_\_\_\_ Secondary Language: **N/A** \_\_\_\_\_

**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, or 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 a history of any **speech/language/stuttering** disorders in your immediate family? **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:**

- NO WORDS**     **WORD APPROXIMATIONS** ("bah-bah" for "bottle")     **SINGLE WORDS** ("ball")  
 **TWO WORDS** ("Bye mommy")     **THREE WORDS** ("That my car")     **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 your child have difficulty latching? <b>Yes</b> <b>No</b>
Weaned from pacifier			
Does your child suck their thumb/fingers?		<b>Yes</b> <b>No</b>	

**Communication goals:**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_