MADISON SPEECH
103 Intercom Drive, Suite C
Madison, AL 35758
256-464-9464

ATHENS SPEECH
1802 US Highway 72 E Suite E
Athens, AL 35611
256-464-9464

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** ________________________

CONTACT INFORMATION: **If child is a minor*

Parent/Caregiver**:** ___________________________ **Legal Guardian: YES NO** Date of Birth: ____ / ____ / _________
Address: ____
Phone: (cell): _______________________ (work): _______________________
Email address: ____ Employer/Occupation: __________________________

Parent/Caregiver**:** ___________________________ **Legal Guardian: YES NO** Date of Birth: ____ / ____ / _________
Address (*If different from above*): ____
Phone (cell): _______________________ (work): _______________________
Email address: ____ Employer/Occupation: __________________________

Persons living in the home: ____

INSURANCE INFORMATION:
Primary insurance: ____ Policy #: ___________________________
Subscriber's name: ____ Subscriber's DOB: ____ / ____ / _______
Patient's relationship to subscriber (please circle): *self* *spouse* *child* *other*________________

Secondary insurance: _____________________________________ **N/A** 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:

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: ____

____

Allergies (*including food allergies*): ____

____

Are there any **speech/language/stuttering** disorders in your immediate family? **YES** **NO**

If **yes**, please explain. ____

EDUCATION:

My child attends: ***Preschool/Daycare:*** ______________________________ ***How many days/week?*** ________

School: __________________________________ ***Grade:*** _______________

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 INDICATE ALL AREAS OF CONCERN REGARDING YOUR CHILD'S COMMUNICATION:

- ○ **Understanding Language**
- ○ **Expressing Language**
- ○ **Articulation/speech sounds**
- ○ **Fluency/stuttering**
- ○ **Voice**
- ○ **Social communication/Pragmatics**

Please describe specific communication goals you have for your child: ______________________________

____

____

WHICH OF THE FOLLOWING DESCRIBES HOW YOUR CHILD COMMUNICATES? **Check all that apply*

- ○ **Pointing, gesturing, reaching**
- ○ **Eye contact, facial expressions**
- ○ **Pulls person to desired object**
- ○ **Babbling**
- ○ **Sign language**
- ○ **Communication book/pictures**
- ○ ____________________
- ○ **Word approximations** ("bah-bah" for "bottle")
- ○ **Single words**
- ○ **Two word phrases**
- ○ **Three-four word phrases**
- ○ **Communication device** ***What kind?*** ____________________________

MY CHILD'S SPEECH IS CURRENTLY UNDERSTOOD BY: **Circle all that apply*

PARENTS **PLAYMATES** **SIBLINGS** **RELATIVES**

NEIGHBORS **UNFAMILIAR LISTENERS**

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%

Does your child exhibit any frustration when they are not understood? **YES** **NO**

Did your child babble or make cooing sounds as an infant? **YES** **NO**

DOES YOUR CHILD CURRENTLY…	**YES**	**NO**	**COMMENTS**
Follow simple 1-2 step directions?			
Point to/go to/reach for people or objects that you name?			
Point to body parts you name?			
Answer simple "yes/no" questions accurately?			
Answer simple "wh" (what, who, where) questions accurately?			
Understand colors & size words?			
MILESTONES	**AGE**	**COMMENTS**	
Babbled/cooed			
Said first words			
Potty Trained			
Weaned from bottle/breast		* If breastfed, did your child have difficulty latching? **YES** **NO**	
Weaned from pacifier			
Does your child suck their thumb/fingers? **YES** **NO**			

CHILD'S INTERESTS:

Please list some of your child's favorite interests (*toys, games, characters, activities, etc.)*:

____

____

____

How did you find out about our clinic?

Pediatrician **Friend** **Social Media** **Community Event** **Google/Online**

Other: ____________________________