SPEECH THERAPY ADDENDUM

Clients Name: _____ DOB: _____

FAMILY HISTORY:

Mother: _____ Age: _____ Occupation: _____

History of Speech, Language or Hearing Problems: Yes ☐ No ☐

If yes, please explain: _____

_____

Father: _____ Age: _____ Occupation: _____

History of Speech, Language or Hearing Problems: Yes ☐ No ☐

If yes, please explain: _____

_____

Is there a family history of any of the following:

Family Member	Family Member
Hearing Loss: _____	Cleft Palate: _____
Speech Problem: _____	Seizure Disorder: _____
Prematurity: _____	Mental Illness: _____
Blindness: _____	Alcoholism: _____
Malformation of The head, neck, or ears: _____	Delayed Motor Development: _____
Educational Difficulties: _____	Low Birth Weight: _____

Other: _____

Drug Use: _____

Does the child live with both parents: _____ If not, whom does the child live with: _____

Have there been any of the following major changes in your family during the last year?

☐ Change of Address ☐ Accident or Illness ☐ Divorce/Marriage

☐ Parent Separation ☐ Birth/Adoption ☐ Death of Immediate Family

Does anyone in the home smoke? ☐ Yes ☐ No

BIRTH HISTORY

Mother's health during pregnancy (note special conditions such as Mumps, German Measles, X-Rays, Serious Accidents, etc.) _____

_____

Anything unusual about the condition of the infant at birth:

☐ Blue Baby ☐ Lack of Oxygen ☐ Convulsions

☐ Rh Problems ☐ Breathing Difficulties ☐ Head Injuries

Others (please describe): _____

Length of Pregnancy: _____ weeks Birth Weight of Infant: _____ lbs. _____ oz.

DEVELOPMENTAL HISTORY

Has your child had any feeding difficulties? Check all that apply:

Sucking or Nursing Excessing Length of Time to Drink Bottle Choking/Gagging

Difficulty chewing or swallowing Meats Regurgitation of Liquids or Solids through Nose

Does your child choke while eating? Yes No If Yes, on what foods? _____

Is your child a picky eater? Yes No If Yes, what foods do they prefer? _____

Describe any feeding problems your baby experienced during the first three months of life:

_____

_____

Does your child drool more than other children of the same age: Yes ☐ No ☐

Did your child have difficulty gaining weight as an infant: Yes ☐ No ☐

Describe any early abnormalities of response to light, sound, and movement:

_____

At approximately what age did your child achieve the following motor milestones?

_____ Head Support _____ Reach & Grasp _____ Sitting Alone _____ Crawling

_____ Standing Alone _____ Walking Alone _____ Climbing Stairs _____ Finger Foods

_____ Eating with Spoon _____ Potty Trained _____ Undresses Self

Rate your child's coordination (Please Circle): Normal | Fair | Poor

Right or left-handed? _____ What age did handedness develop? _____

Did anyone try to influence handedness? (describe) _____

Any abnormalities in early physical development:

_____

_____

MEDICAL HISTORY

Childhood illnesses and injuries list: Illness, age, amount of fever, after-effects (if any)

Earaches: _____

Ear-Drainage: _____

Pneumonia: _____

Convulsions: _____

Measles: _____

Child Case History

Chickenpox: _____

Frequent Colds: _____

Bronchitis: _____

Allergies (describe): _____

Asthma: _____

Enlarged adenoids: _____

Tonsillitis: _____

Concussion: _____

Serious Injuries: _____

Others (describe): _____

Operations (describe): _____

If your child has had fevers, how long do they last? _____

Check any of the following drugs that your child has taken: Quinine ___ Streptomycin ___ Nicotine ___

Frequent Aspirin _____ Neomycin _____ Others _____

Name any medicines the child is currently taking: _____

Child's present health _____

Has the child had an eye examination? _____ When? _____

PLAY BEHAVIORS

Which of the following describes the type of play your child likes to engage in the most often?

____ Putting Toys in Mouth

____ Shaking Toys

____ Appropriate use of Objects

____ Uses one object for another

____ Acting out Familiar Routines

____ Games with Rules

____ Looking at Books

____ Banging Toys Together

____ Pushing/Pulling Toys

____ Throwing Toys

____ Make Believe Play

____ Role-Playing

____ Rough and Tumble Play

What is the average length of time your child can stay playing one activity?

_____

What activities seem to hold your child's attention for the longest period of time?

_____

What activities seem to hold your child's attention for the shortest period of time?

_____

Is your child's play easily distracted by any of the following:

_____ Visual stimuli (i.e., other toys or objects)

_____ Auditory Stimuli (i.e., voices, sounds outside, the TV)

_____ Nearby Activities

_____ Other People in the Room

Whom does your child prefer to play with (circle all that apply)

Mother | Father | Sibling | Self | Other Children | Other Adults

PERSONALITY

What are the child's chief interests?

_____

_____

How often does the child exhibit the following characteristics: (often, sometimes, never)

Nervous _____

Sleeping Problems _____

Bed Wetting _____

Thumb Sucking _____

Nightmares _____

Nail Biting _____

Destructive _____

Temper Tantrums _____

Co-Operative _____

Day Dreaming_____

Shyness _____

Aggressive _____

Inferiority Complex _____

Jealousy _____

Fearful _____

Showing Off _____

Quiet _____

Selfish _____

Eating Problems _____ Leadership _____

Happiness _____ Friendliness w/ Adults _____

Stealing _____ Friendliness w/ Children _____

Explosive Behavior _____ Unusual Fears (describe) _____

Describe any discipline problems you have with your child

_____

_____

What problems does the child have, if any, in school?

_____

_____

SPEECH HISTORY

What languages are spoken at home? _____

Which are spoken by the child? _____

Which are understood by the child? _____

Indicate when your child first demonstrated the following:

Age	Behavior	Age	Behavior
____	Cooing, pleasure sounds	____	Single Words
____	Phrases (go bye-bye, more juice)	____	Jargon (talking own special language
____	Short Sentences	____	Babbling (ba-ba, da-da, etc.)

What is the primary method(s) your child uses for letting you know what s/he wants?

____ Looking at Objects	____ Pointing at Objects	____ Gestures
____ Crying	____ Vocalizing/Grunting	____ Physical Manipulation
____ Single Words	____ 2-3 Word Combinations	____ Sentences

Which of the following best describes your child's speech?

_____ Easy to understand

_____ Difficult for parents to understand

_____ Difficult for others to understand

_____ Almost never understood by others

_____ Different from other children of same age

Which of the following best describes your child's reaction to his/her speech?

_____ Is easily frustrated when not understood

_____ Does not seem aware of speech communication problem

_____ Has been teased about his/her speech

_____ Tries to say sounds or words more clearly when asked

_____ Is successful in saying sounds or words more clearly when s/he tries

Does your child have difficulty producing certain sounds? ____ Yes ____ No

If yes, which ones? _____

Does your child hesitate and/or repeat sounds or words? ____ Yes ____ No

Does your child "get stuck" when attempting to say a word? ____ Yes ____ No

Do you have concerns about your child's voice? ____ Yes ____ No

Which of the following do you think your child understands?

____ His/her own name ____ Names of body parts ____ Family names

____ Names of objects ____ Simple direction ____ Complex direction

____ Conversational speech

What is the parents' reaction to child's speech?

_____

_____

What is the child's attitude toward own speech?

_____

_____

When was the speech difficulty first noticed? _____

By whom? _____

Describe the child's present speech? _____

_____

What changes have you noticed in the child's speech since the difficulty was first noticed? _____

_____

Has your child received speech treatment? _____ How long? _____ By Whom? _____

Results: _____

HEARING HISTORY

Describe any hearing difficulties:

_____

Has child had hearing tested? _____ When? _____ By whom? _____

Does the child have a hearing aid? _____ Does s/he use it? _____

Listening Habits:

Ability to hear on the telephone: _____ Ear used: _____

Radio/Stereo/TV:

_____

Ability to hear in groups:

_____

Ability to understand in quiet:

_____

Ability to understand noise:

_____

Ability to locate direction of sound:

_____

STATEMENT OF PROBLEM

Please state in your own words what you think the child's problem is, and what you think might have caused it:

_____
_____
_____

When did you first notice the problem?

_____
_____

Whom did you first tell about this problem?

_____

What was this person's response?

_____
_____

What is your child's awareness of their reaction to this problem?

_____
_____

How do you and other family members react to this problem?_____
_____

What information do you hope to gain from this evaluation, and what specific questions or areas do you wish to address?

_____
_____
_____

Form Completed By: _____

(Sign your name)

Relationship to Client: _____

Date: _____

PERMISSION FOR TESTING AND TREATMENT

Approval is hereby given for our child to receive the appraisal services and treatment if warranted offered by TAG Therapy INC. I understand that this evaluation and treatment will be done in the interest of the child's education development and will be supervised by a state licensed and ASHA certified Speech-Language Pathologist.

Signed: _____

_____

Relationship to Patient

Date: _____

PERMISSION TO RECORD/PHOTOGRAPH/OBSERVE

I hereby authorized TAG Therapy INC. for Speech and Language Disorders, exercising due discretions, for education and scientific/professional purposes, as in the public interest, to make customary and constructive use of information, photographs, and sounds recording, films and other records or materials pertaining to, and in consideration of, my enrollment, examination, instruction, and scientific participation, or that of my minor child(ren) _____ for whom I am legally responsible.

Signed: _____

_____

Relationship to Patient

Date: _____