Phone: 773-388-8918
Fax: 773-388-8914
2925 N. Southport Suite 202 Chicago, IL 60657
speechinthecity@sbcglobal.net

Today' Date: _____

Patient Information

Child's Name:_____ Date of Birth:_____ _

Parent or Guardian's information:

Mother's Name:_____

Father's Name:_____

Guardian's Name:_____

Address:_____

City:_____ Zip:_____

Home Phone:_____ Alt. Phone:_____

Email address:_____ Would you like to receive emailed statements?_____

Names and ages of
siblings:_____

_____

Referred by:_____

Name of Pediatrician:_____

Pediatrician's contact information:

_____

Diagnosis:_____

Does your child have any allergies?_____ If yes please specify: _____

_____

Is your child in a child care program, preschool, or school?_____

If so, where and what grade?_____

_____

Insurance Information

Insurance Company:_____

Policy holder's name and date of birth:_____

ID#:_____ Group #:_____

Does your Insurance require pre-certification?_____

Please answer the following questions:

1. Describe your major concern(s) about your child_____

   _____

   _____

   _____

   _____

2. When was your child's most recent medical exam?_____
3. Does your child have a history of middle ear infections? If so were tubes placed?_____

   _____

4. Has your child ever experienced any difficulty with feeding of swallowing? If so please explain:_____

   _____

   _____

   _____

   _____

Birth and developmental history

Was pregnancy and delivery normal?_____

_____

Was pregnancy full term?_____

Did your child require intubation after birth?_____

At what age did you child:

Sit alone:_____

Stand alone:_____

Walk alone:_____

Babble:_____

Speak first word:_____

Put two words together:_____

Has a hearing test been completed?_____ What were the results?_____

Has your child previously been seen for speech and language therapy?_____

If yes, please

explain:_____

_____

_____