



Phone: 708 351-7805
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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 or 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: _____

