the hello CLINIC
speech & occupational therapy

*Medical & Developmental History*

Date _____

Child's Name _____ Child's Birthdate_____

Parent/Guardians: _____

Primary Language at home _____ Other language exposure _____

# Background Information

What concerns brought you to The Hello Clinic today and when did these concerns first surface?

_____

_____

_____

What do you hope to gain from today's evaluation? What questions do you have?

_____

_____

_____

What are your child's strengths?

_____

_____

What are your child's challenges?

_____

_____

What are your child's favorite toys and activities?

_____

_____

Does your child:

| | | |
|---|---|---|
| speak/articulate as well as peers? | ☐ No | ☐ Yes |
| use language as well as peers? | ☐ No | ☐ Yes |
| understand language as well as peers? | ☐ No | ☐ Yes |

Has your child had any previous evaluations (OT, PT, speech, psych, developmental ped., cognitive, etc)?

_____

_____

_____

Does your child have any diagnoses (hearing loss, ASD, ADHD, anxiety, apraxia, speech or language delay, etc. ).
**Please provide documentation of diagnoses at time of visit.**

Has your child had a hearing test? ☐ No ☐ Yes When? _____ Results: _____

Has your child had previous support services or therapy (including OT, PT, speech, counseling, early intervention, tutoring)?

# Child Care / School

Child Care provider name _____

Schedule/frequency _____

Early Intervention (EI) / Early Childhood Special Education (ECSE) ☐ No ☐ Yes
**please provide documentation at time of service (IFSP, evaluation report, progress notes, etc.)

Describe services _____

Schedule / Frequency _____

Name of school _____ Grade level _____

☐ On an IEP ☐ On a 504 ☐ Tutor

What are your child's academic strengths? _____

What are your child's academic challenges? _____

What best describes your child's reading level? Check one:

☐ below grade level ☐ at grade level ☐ above grade level

# Family History

| | Name | Living with child | Age | Medical Diagnoses |
|---|---|---|---|---|
| Mother | | ☐ | | |
| Father | | ☐ | | |
| Siblings | | ☐<br>☐<br>☐<br>☐ | | |
| Other household members | | ☐<br>☐<br>☐ | | |

Any history of hearing loss, speech or language difficulties, or learning impairments in your immediate or extended family? If yes, please explain.

# Medical History

Was your child born prematurely? By how many weeks?

Any complications at birth that required an extended stay at the hospital? Explain.

List any hospitalizations, serious illness, accidents or surgery. Please include date (or approximate age).

Immunizations: ☐ elected not to immunize ☐ delayed schedule ☐ up-to-date

Please check all that apply:

- ☐ dental/orthodontic issues
- ☐ hearing loss
- ☐ ear infections
- ☐ allergies
- ☐ asthma
- ☐ snoring
- ☐ hoarse voice
- ☐ sleep concerns
- ☐ seizures
- ☐ concussions
- ☐ vision problems
- ☐ medications

Add detail:

Are there any feeding/swallowing concerns (currently or previously)?

- ☐ chewing and swallowing
- ☐ choking or gagging
- ☐ history of reflux
- ☐ difficulty nursing
- ☐ eats non-food items
- ☐ tongue tie
- ☐ picky eater
- ☐ special diet
- ☐ other

Add detail:

# Developmental History

| GROSS MOTOR | Typical | Delayed | Specific Age |
|---|---|---|---|
| Crawling | | | |
| Walking | | | |
| Riding a bike | | | |
| Jumping | | | |

Additional Comments:

| ADAPTIVE | Typical | Delayed | Specific Age |
|---|---|---|---|
| Feeding self | | | |
| Dressing self | | | |
| Toileting | | | |
| Grooming/ hygiene | | | |

Additional Comments:

| SOCIAL & PLAY | Never | Sometimes | Often |
|---|---|---|---|
| Initiates with peers | | | |
| Uses eye contact | | | |
| Takes turns | | | |
| Interacts with peers | | | |
| Pretend plays | | | |

Additional Comments:

| FINE MOTOR | Typical | Delayed | Specific Age |
|---|---|---|---|
| Pincer Grasp | | | |
| Point with isolated finger | | | |
| String beads | | | |
| Point with isolated finger | | | |
| Cut out circle | | | |
| Write name | | | |

Additional Comments:

| SPEECH & LANGUAGE | Typical | Delayed | Specific Age |
|---|---|---|---|
| Babbling | | | |
| Pointing | | | |
| First words | | | |
| Combining words | | | |
| Using sentences | | | |
| Follows simple directions | | | |
| Responds to name | | | |
| How much of your child's speech do you understand? ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ other | | | |

Additional Comments:

## BEHAVIOR

Check all that apply

Additional Comments:

- ☐ Frequent tantrums
- ☐ Hitting / Kicking / Aggression
- ☐ Shyness
- ☐ Difficulty separating from parent or caregiver
- ☐ Getting stuck on any topics or type of toys

# Availability for Sessions

If therapy is recommended, what is your child's availability? Check all that apply:

| | 8-12 | 12-3 | 3-6 |
|---|---|---|---|
| Monday | | | |
| Tuesday | | | |
| Wednesday | | | |
| Thursday | | | |
| Friday | | | |

Additional comments:

Since 2005, we have offered online therapy to clients that would benefit from appointments with a specialist while staying in the comfort of their home. We can offer a free consultation to see if you are a candidate for online therapy.

Are you interested in a free consultation for online therapy? ☐ No ☐ Yes ☐ Maybe

Do you have a computer and wi-fi at your home? ☐ No ☐ Yes ☐ Unsure

What time of day is most convenient for you? ☐ Morning ☐ Afternoon ☐ Evening