Date: _______________

Child's Name: ____

Address: ____

D.O.B.: ______________________

Age: _________________________

Filled out by: ____

Others present: ____

Mother/Father's name: ____

Address: ____

Phone Number: ______________________________

Mother/Father's name: ____

Phone Number: ______________________________

Address (if different from first parent):

____

Referred by: ____

rachel@rachelkirsonslp.com (914) 584-5486 www.rachelkirsonslp.com

Please put N/A *Not Applicable* for all questions that do not apply

School & Grade (if applicable):

____

What languages are spoken in the home?

____

Who is the primary caretaker of the child? (e.g. spends most of the day with, feeds child, spends time with after school, etc):

____

____

Past surgeries, injuries, serious illnesses or hospitalizations:

____

____

____

Previous Evaluations (Please list professional's name and date):

____

____

____

Audiological Evaluation:

Where	When	Results

RachelKirson
SPEECH LANGUAGE PATHOLOGIST

Parental Concerns:

____

____

____

____

Current Therapies:

Type	Frequency

Feeding:

	YES/NO
Pacifier	
Bottle	
Straw	
Cup	
Fork	
Spoon	

How does your child typically communicate? (Check all that apply)

Gestures	
Pointing	
Pulling/Grabbing	
Single Sounds (e.g. Ahh)	
Single Words	
Short Phrases	
Sentences	

If your child communicates using **single sounds and words**, please list those sounds and words below:

____

____

____

____

Does your child avoid any tastes, textures, or temperatures?

____

____

Describe your child:

____

____

____

Additional Information:

____

____

____

Please attach or email any previous and/or recent evaluations (e.g. Early Intervention, CPSE, CSE, Neuropsychological, Developmental Pediatrician) from other professionals to rachel@rachelkirsonslp.com .