Yardley Speech and Language

Child's Name:		
Today's Date:		
Child's Date of Birth:		
Name and Address of Child's Primary Care Physician		
Name of Person Filling out this Form	**Print**	**Sign**

Contact Information

Parent/Guardian	Cell Phone Number	Email Address	Postal Address	Custodial? (Y/N)

Reason for Referral

Speech/Language Concerns

School Related Concerns

Name and town of school:	Grade:
Concerns:	

Physical Concerns

Social/Emotional Concerns

With whom does the child live?

Name	Relationship to Child	Occupation	Age

Other Languages Spoken in the Home	

Birth Information

- ☐ Born with no apparent complications
- ☐ Born premature
- ☐ Weighed less than 5 1/2 pounds at birth
- ☐ Spent time in the neonatal intensive care unit
- ☐ Required assistance with breathing
- ☐ Born past due date
- ☐ Newborn Feeding Concerns
- ☐ Other

Developmental Milestones

	Early	Typical	Late	Unknown	Not yet
Sitting up Alone					
Crawling					
Walking Alone					
Babbling					
Speaking First Words					
Speaking Short Sentences					
Eating Solids					
Using Toilet When Awake					
Staying Dry All Night					

Health History

Condition	Previously Diagnosed (when?)	Currently Diagnosed?	Treatment
Allergies			
Anxiety			
Asthma			
Attention Deficit Disorder			
Auditory Processing Disorder			
Autism Spectrum Disorder			
Balance Difficulties			
Brain Tumor			
Cerebral Palsy			
Cognitive Delay			
Cleft Palate			
Chromosomal Abnormalities			
Concussion			
Diabetes			
Down Syndrome			
Ear Infections			
Feeding Difficulties			
Fetal Alcohol Syndrome			
Loss of Consciousness			
Muscular Dystrophy			
Pressure Equalization (PE) Tubes in Ears			
Seizures			
Sensory Processing Disorder			
Sleeping Problems			
Surgery (please specify)			
Stroke			
Tic			
Traumatic Brain Injury			
Other: _____			

Previous Evaluations

	Date	Facility	Results	Recommendations
Vision				
Hearing				
Developmental				
Psychological				
Neurological				
Other _____				

Therapy

	Dates (From-To)	Facility	Number of Times Per Week
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Other _____			

Current Medications

Medication	Dosage	For the Treatment of

Family History of Speech/Language/Learning/Movement Problems

Name	Relationship to Child	Issue

Child's Interests
