Kelli Murdock Eickelberg, MA, CCC-SLP
Speech-Language Pathologist

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NEW PATIENT INFORMATION

Patient's Name:____

Date of Birth:____

Gender: Female_____ Male_____

Parent/Guardian's Names (if applicable):____

____

Address:____

City:____

State:____

Zip Code:______________________

Home Phone:__________________________________ Cell phone:____

Email:____

Primary Care Physician:____

Diagnosis (if known):____

Reason for referral:____

Referred by:____

Are other languages spoken in the home? Yes_____ No_____

What languages?____

BIRTH HISTORY:

Was your child born: Pre-Term (before 37 weeks)_______

(circle one) Term (37-42 weeks)______

Post-Term (after 42 weeks)______

Complications with Pregnancy?____

____

Complications with Delivery?____

____

Birth weight?_________________

Birth height?_________________

APGAR Scores? 1 min.______________

5 min.______________

DEVELOPMENTAL HISTORY:

-When did child begin to coo (make sounds in response to your interactions)?____

-When did child begin to babble (purposefully play with sounds)?____

-When did child begin to use Single words?____

-When did child begin to string words together?____

CURRENT COMMUNICATION MODE:

Please describe how your child currently communicates his/her needs, desires and information with you: ____

____

How well is your child understood by you or close family members (out of 10 words, how many do you understand?)?____

-Does your child have difficulty
with social interactions? Yes _____ No_____

Please describe: ____

____

SOCIAL COMMUNICATION:

Does your child (yes or no):

Make eye contact_____
Take turns_____
Use gestures_____
Point_____
Hand-guide_____
Request items or actions_____
Command others_____
Protest_____
Express displeasure______
Explore his/her environment_____
Like to pretend or make-believe_____

Greet others?_____
Use language to inform?_____
Use language to satisfy needs?_____
Use language to ask questions?_____
Stay on topic?_____
Interrupt other frequently?_____
Revise his/her statements?_____
Use polite forms of speech?___
Provide enough but not too much information?_____
Organize his/her thoughts well?_____
Understand humor?_____

PLAY SKILLS:

-Please describe your child’s likes and interests:

____

Does your child play with others? Yes_____ No_____

Does your child play alone? Yes_____ No_____

MEDICAL HISTORY:

Please mark all that apply to your child.

Middle ear infections?_____At what age?___________________

Ear tubes?_____ When?___________________

Hearing loss?_____At what age?________________

Frequent colds?_____

Tonsillitis:_____Has your child had his/her tonsils removed?_____When?________________

Adenoid issues?_____Has your child had his/her adenoids removed?_____When?_________________

Allergies?_____Seasonal?_____What is your child allergic to?____________________________________

Asthma?_____At what age?_____________________

Sinus Problems:_____Does your child take medication for this?_________________________

Snoring?_____Frequency?______________________

Reflux?_____Does your child take medication for this?_____

Seizures?_____Does your child take medication for this?_____

Heart murmur?_____

FEEDING HISTORY:

Was your infant bottle or breast fed (or both)?_________________For how long?_____________________

Did your child ever demonstrate feeding difficulties? If yes, please explain.__________________________

____

Does your child eat quickly, slowly, or an average rate?____

Does your child frequently cough when eating or drinking?____

Does your child frequently have liquids come through his/her nose when drinking?_____________________

Does your child chew adequately?____

Does your child have aversions to certain textures, temperatures, or flavors of foods (if yes, please describe)?

____

Does your child burp frequently during or after meals (if yes, please describe)?_________________________

____

Does your child have a special diet (if yes, please describe)?____

____

DENTAL HISTORY:

Has or does your child suck his/her thumb or fingers?_____ Until what age?_______________

Did your child ever frequently use a pacifier?_____Until what age?________________

Has your child had issues with baby teeth or permanent teeth (if so, please describe)?_______________

____

Is your child being seen regularly by a dentist?_____If so, whom?____________________________________

Does your child ever complain of dental pain (if so, please describe)?_________________________________

____

Does your child grind his/her teeth at night?_____

Does your child see an orthodontist?_____If so, whom?____

Does your child have any orthodontic appliances in place at this time (if so, please describe)?______________

____

ORAL BEHAVIORS:

Does your child breath through their mouth, nose, or both?____

When your child is at rest, is his/her mouth open or closed?____

Does your child have chronic dry lips or lick their lips frequently?____________________________________

Does your child seek things to chew (if yes, please describe)?_______________________________________

COMPLETED EVALUATIONS:

Speech-Language Pathologist:

Yes_____ No_____

Date:___________By Whom:____

Results:____

Audiologist (Hearing Testing):

Yes_____ No_____

Date:___________By Whom:____

Results:____

Developmental Pediatrician:

Yes_____ No_____

Date:___________By Whom:____

Results:____

Psychologist:

Yes_____ No_____

Date:___________By Whom:____

Results:____

Occupational Therapist:

Yes_____ No_____

Date:___________By Whom:____

Results:____

Physical Therapist:

Yes_____ No_____

Date:___________By Whom:____

Results:____

ABA therapist:

Yes_____ No_____

Date:___________By Whom:____

Results:____

EDUCATIONAL INFORMATION:

-Does child receive early intervention services? Yes_____ No_____

How Often?____

Where?____

-Does child attend school? Yes_____ No______

Where?____

What grade?__________________________

-Does child receive special education
services in school? Yes_____ No______

Please describe:____

Thank you for taking the time to fill out this information. It will assist me in planning for your child. If you have any questions, please call or email me.

Sincerely,

Kelli

Kelli Murdock Eickelberg, MA, CCC-SLP
Licensed Speech-Language Pathologist