advantage
speech therapy services

Your Child's Safety is Our Top Priority

In order to ensure the safety of your child during his/her in-home therapy session, it's imperative that an adult be present in your household at all times. While it's not mandatory that a parent/caregiver join the actual session, it can be beneficial.

Note: This form provides developmental milestones and information necessary to better understand your child as we move forward.

Patient Info

Patient Name

First

Last

Nickname

DOB

/ /

Sex

☐ Male ☐ Female

Address

Street Address

Address Line 2

City

State

Zip Code

Apartment #

Name of Apartment Complex or Sub-division

Access/Gate Code

Will therapy need to be conducted outside the home?

I travel to your child at the parent/guardian home. Is there an alternate location outside the home to visit? Eg, daycare, babysitters, church, preschool program? If "Yes", please share the details below.

Name of Alternate Location

Examples: Goddard, Primrose, Daycare, Baby sitter, Neighbor, ...

Contact Name

First

Last

Address

Street Address

Street Address 2

City

State

Zip

Phone

Email

Referral Questions

Reason for Requesting Services

Your Child's Specific Diagnosis

How did you learn about Advantage Speech?

Friend, Doctor, Therapist, Other?

Parent/Caregiver Info

Patient/Caregiver Name (#1)

Relationship to Child

DOB / /

Address

Street Address

Address Line 2

City

State

Zip Code

Cell Phone

Email

Alternate Phone

Alternate Phone Type

☐ Work ☐ Cell ☐ Home

Is there a second Parent/Caregiver?

☐ Yes ☐ No

Parent/Caregiver Info (#2)

Patient/Caregiver Name (#2)

Relationship to Child

DOB / /

Same address as Parent/Caregiver #1?

☐ Yes ☐ No

Address

Street Address

Address Line 2

City

State

Zip Code

Cell Phone

Email

Alternate Phone

Alternate Phone Type

☐ Work ☐ Cell ☐ Home

Medical

Pediatrician/Primary Doctor Name | **Phone** | **Fax**

Address

Street Address

Address Line 2

City | State | Zip Code

Insurance

Primary Insurance

Subscriber's ID | **DOB** / / | **Group #**

Subscriber's Name | **Relationship to Child** | **Phone**

Secondary Insurance Available?
☐ Yes ☐ No

Secondary Insurance

Subscriber's ID | **DOB** / / | **Group #**

Subscriber's Name | **Relationship to Child** | **Phone**

Family Members

Parents | **Brothers & Ages** | **Sisters & Ages**

Additional row for parent(s) / sibling(s):

Please list & describe any Family Members with a history of...

... a known speech, language, fluency and/or hearing concern

Is your child bilingual?
☐ Yes ☐ No

What language(s) are spoken in the home?

English, Spanish, ... ?

Child's primary language?

Child's secondary language?

Child's Communication Style

Please describe your child's difficulty with communicating and how it impacts his/her daily activities

How does your child typically communicate? How does your child express his/her wants and needs?

Check the ones that apply.

☐ Gesture ☐ Sign language ☐ Grunting ☐ Pointing/Pulling ☐ Talking (select all that apply below) :

Talking Styles...

☐ Jargon/Unintelligible Speech ☐ Single Words ☐ Word Combinations

Is your child aware of their difficulty in communicating?

☐ Yes ☐ No

How does it impact him/her?

How would you describe your child's ability to speak clearly?

☐ In error, but understandable ☐ Difficult to understand ☐ Requires careful listening

☐ I don't understand much of what he/she says ☐ _____ Other..

Can an unfamiliar listener understand him/her?

☐ Yes ☐ No

Does their teacher have trouble understanding him/her?

☐ Yes ☐ No

What % do you as the caregiver understand him/her?

Which caregiver are you?

☐ Mom ☐ Dad ☐ _____ Other

At what age did your child stop using the pacifier?

At what age did your child stop drinking form a bottle?

Has your child been in therapy before?

☐ Yes ☐ No

Specify the Discipline(s)

OT, Speech, PT, ABA or Other

When and with whom did they see?

Has your child had a speech evaluation?

☐ Yes ☐ No

Date of Speech Evaluation

__/__/__

Does your child receive speech in the school?

☐ Yes ☐ No

Do they have an active IEP?*

☐ Yes ☐ No

Do you have a copy of their IEP to provide ASTS?*

☐ Yes ☐ No

What goals did they address?

(Examples may include: walking, talking, sensory motor, behavior, language)

Medical History/Milestones

How was the child's mother's health during pregnancy?

Any complications during birth?

☐ Yes ☐ No

Describe anything unusual during or immediately following the birth

Has your child been hospitalized?

☐ Yes ☐ No

What was the reason?

Does your child take any medication?

☐ Yes ☐ No

Please list medication and reason

Does your child have difficulty eating?
☐ Yes ☐ No

Please describe their difficulty with eating.

How does your child get along with other children and/or siblings?

At what age did your child... (Please indicate year or month. E.g., 1 year, 7 months, 1 yr 3 mos, etc.)

Crawl

Babble

Dress Self

Sit

Use first Word

Use toilet

Stand

Use 2+ words

Feed Self

Walk

When was the most recent hearing screening and/or evaluation?
/ /

Who conducted the test? Please specify the doctor.

What were the results?
Pass/Fail Left ear, Pass/Fail Right ear

Did your child receive tubes in his/her ears?
☐ Yes ☐ No

When?
/ /

Additional Info

What activities does your child enjoy participating in?

What frustrates your child?

What are his/her strengths?

What are his/her weaknesses?

What would you most like to see your child gain from speech therapy?

Does your child have any known food (or other) allergies?
If so, please specify.

Additional comments:

Thank you for taking the time to help us understand your child's family/medical history, and developmental level.
This information will help us appreciate your child's strengths and weaknesses in order to address specific goals to increase their communication skills!