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OFFICE USE ONLY	
ID	
DATE	
OTHER	LITERACY

Please provide the following information:

CHILD'S INFORMATION			
FULL NAME		GENDER ☐ Male ☐ Female	DOB
CURRENT AGE	NAME OF SCHOOL		GRADE
PCP		PCP PHONE	
DESCRIBE YOUR MAIN CONCERNS Include when the problem was first noticed, how it has progressed, and any other information you feel is relevant			
How did you learn about us?			

In the table to the right, list all other services your child has received, including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below.

☐ None

TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER

Continue to next page.

FAMILY'S INFORMATION

With whom does your child live? (Check all that apply)	☐ Biological parent(s) ☐ Adoptive parent(s) ☐ Legal guardian(s) ☐ Grandparent(s) ☐ Sibling(s) ☐ Other:

In the table to the right, list all family members who live in the same home as your child.

NAME	AGE	RELATION TO CHILD

PARENT 1 INFORMATION

FULL NAME	GENDER ☐ Male ☐ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 ☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2 ☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT ☐ PHONE 1 ☐ EMAIL ☐ PHONE 2	
PLACE OF EMPLOYMENT	POSITION	

PARENT 2 INFORMATION

FULL NAME	GENDER ☐ Male ☐ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 ☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2 ☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT ☐ PHONE 1 ☐ EMAIL ☐ PHONE 2	
PLACE OF EMPLOYMENT	POSITION	

Are there family circumstances that would be helpful to share with your child's therapist? (e.g., custody arrangements)	
Are there any other languages spoken in the home? If yes, which language(s) and how often?	

Do any other family members have speech, language, or related difficulties or disorders? (e.g., ADHD, autism)

RELATION TO CHILD	RELATED DIAGNOSIS/DISORDER

CHILD'S HEALTH BACKGROUND		
Has your child's hearing been tested? ☐ Yes ☐ No If yes, when and where?		☐ Passed ☐ Did not pass
Describe any serious illnesses, injuries, or medical procedures your child has experienced.		
List any environmental or food allergies.		
List any routine medications your child is currently taking or has taken long term.		
Describe any other conditions or diagnoses identified by your child's doctor or other professionals.		

CHILD'S SPEECH AND LANGUAGE DEVELOPMENT		
At what age did your child begin:	☐ BABBLING (bababa) _____ months ☐ FIRST WORD_____ at _____ months ☐ THREE-WORD COMBO _____ months/years ☐ READING LETTERS _____ years ☐ READING WORDS _____ years ☐ READING SENTENCES _____ years	☐ JARGON (bada bama) _____ months ☐ TWO-WORD COMBO (more milk) _____ months ☐ SENTENCES _____ months/years ☐ WRITING LETTERS _____ years ☐ WRITING WORDS _____ years ☐ WRITING SENTENCES _____ years
Has your child previously had a speech-language evaluation or a reading evaluation (including for an IEP)? If yes, please note the place and date and summarize the findings.		
Is your child aware of his/her reading difficulties?		

CHILD'S STRENGTHS AND FAVORITES	
Describe your child's strongest skills and personality traits. What makes your child unique?	
FAVORITE ACTIVITIES / HOBBIES	
FAVORITE MOVIES	
FAVORITE BOOKS	

Thank you for taking the time to complete this information about your child.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE