Speech-Language Pathologist:
Michelle Nayberg M.S. CCC-SLP
Contact:
Email: info@speakeasytherapy.org
Phone: (267) 991-0190

Preliminary Information

Name: _____ Date: _____

DOB: _____ Age: _____ Gender: M/F

Address: _____ Emergency Contact: _____

Email: _____ Insurance (Name & Member ID): _____

Primary Care Physician: _____ Contact: _____

Primary Language: _____ Other languages spoken: _____

Primary Concerns: _____

_____

_____

_____

Developmental History

- Full Term (40 weeks) **Y/N** If no, when was the child delivered? _____
- Birth Weight: _____ lbs. _____ oz.
- Any complications during pregnancy? _____
- Did the child pass their newborn hearing screening?
- History of ear infections? **Y/N**
- Recent hearing/vision screenings? **Y/N**
- Any diagnoses? _____
- Any family history of speech and language disorders or delays?
  _____
- When did the child start to:
  -crawl: _____ -walk: _____ -talk (first words): _____
  -two words: _____

Other Information:

- Is your child understood by:
  -Parents: **Y/N**
  -Playmates: **Y/N**
  -Relatives: **Y/N**
  -Unfamiliar listeners: **Y/N**

- Does your child have any feeding/swallowing difficulties?

If yes, please describe: _____

- Does your child utilize AAC? **Y/N**

If yes, what type**:** _____

- Does your child receive other therapeutic services? ie. OT, PT, ABA, etc.

  _____

- Describe their typical day (daycare/school?): _____

  _____

- Have they ever been evaluated for speech services before? **Y/N**

  If yes, when? _____

- Behavioral Concerns? **Y/N** If yes, describe them: _____

  _____

  _____

- Concerns with Play Skills/Social Emotional Skills: **Y/N**

  If yes, describe them:

  _____

  _____

  _____

Additional Comments/Concerns: