Vista Rehab Services, P.A.
Serving persons with special needs

Director
Kathleen McEwen, MS CCC

185 Green St. Suite 100, Woodbridge, NJ 07095
Tel. (732)634-5980 Fax (732)634-9508
Email: vistarehabservices@gmail.com

BACKGROUND INFORMATION

Child's Name ____ Birthdate ____________________

Address ____Phone_________________
Street City/State/Zip

Information Given By ______________________________Relationship to Child ______________
Referring Physician ____Phone _______________
Address____
Pediatrician (if different from above)____
Address____
Other Referral Sources, if any (school, family, etc.)
____
Medical Diagnosis (if known) ____

FATHER: Name____Age _______________
Address ____Phone______________
(IF DIFFERENT FROM ABOVE)
Occupation ______________________Highest Level of Education _______________
Business Address____________________________________Phone______________
MOTHER: Name____Age______________
Address____Phone_____________
(IF DIFFERENT FROM ABOVE)
Occupation______________________Highest Level of Education_______________
Business Address____________________________________Phone_____________

OTHER CHILDREN IN THE FAMILY:

Name	Age	Grade in School	Any speech, learning or physical problems?

Are there relatives, on either side of the family, who have had: Speech Problems?____________
Hearing problems?____________Psychological or physical disabilities such as epilepsy, cerebral palsy, cleft lip or palate, autism, downs syndrome
retardation?____
____

Are there other languages spoken in the home?_____Primary_______________Other_________

PARENT'S REPORT

1. Describe your child's speech problem.____
____
____
____
____
____
____

2. Please explain what you hope to learn from this evaluation.____________________________
____
____
____
____

BIRTH HISTORY

1. During this pregnancy, did mother experience any unusual illness, condition or accident such as German measles, Rh incompatibility, false labor, anemia, bleeding, diabetes, etc.? If so, please describe.____
____
____

2. Was any medication taken during pregnancy?____
____

3. Length of pregnancy ______________Duration of labor______________________________
Birth weight _____________ Were any drugs or anesthetics used during abor?___________
Were there any problems with delivery, such as breech birth, caesarian, induced, interrupted, etc.? If so, please describe.____
____
What was the APGAR rating at the time of birth, if known?__________________________

4. Conditions immediately following birth: Did infant have trouble starting to breathe?_____
Was infant blue?__________Jaundiced?__________Convulsions?_____________________
Scars, bruises or head injury?__________Sucking or swallowing difficulty?____________
Unusual muscle tone?_________ Other problems?__________________________________
Describe any medical attention mother or child required.___________________________
____

DEVELOPMENTAL HISTORY

1. Was the child able to hold up his/her head alone?__________________________________
2. When did he/she sit alone without support?____
3. When did he/she crawl?____

DEVELOPMENTAL HISTORY (con't)

4. When did he/she pull himself/herself to a standing position?___________________________
5. When did he/she walk unaided?____
6. Feeding: Was your child breast fed or bottle fed?__________Were there any feeding problems at birth?________________________Was there sufficient weight gain?_____ At what age did he/she start drinking from a cup?_________Straw drinking?_____________ Did or does he/she have any particular food preferences, dislikes or allergies, or any special Dietary restrictions?____
____
7. Does he/she have dental problems?_______________Thumb sucking, etc._______________ Pacifier use_____________ Describe:____
8. Does child have any problem swallowing or chewing when eating?____________________ Does child drool?________Does child breathe through his/her mouth constantly?________
9. Is child toilet trained?______ When was toilet training completed?_____________________
10. When did the child dress himself/herself completely?__________Is he/she able to: Tie a bow?_______Button?_______Zip?_______Snap?_______
11. Which hand does child prefer when he/she: Throws?____Eats?____Writes/draws?_____
12. Does child fall frequently?_______How well can he/she climb?______________________ Play ball?______________________________Run?__________________________________ Do you feel child is well coordinated?____
13. Does your child avoid touching certain things i.e. sand, grass, play do?________________

MEDICAL HISTORY

1. What has been the child's general health condition?______________________________
2. Has child been in the hospital since birth?______If so, explain (operations, accidents, etc.) and give his/her age at this time.____ ____
3. Does child have any problem hearing?_______Has he/she had ear infections, running ears, myringotomies/tubes?________If so, explain frequency, severity and age._________ ____ ____
4. Does child see normally?_________Does he/she have glasses?_______________________
5. List any medicine your child takes regularly (except vitamins) and why._______________ ____
6. Has child been seen by any of the following? If so, give name/address/date of evaluation.
   Optomologist____
   Neurologist____
   Psychologist____
   Audiologist____

MEDICAL HISTORY (con't)

Speech/Language Pathologist____
Physical Therapist____
Learning Specialist____
Child Study Team____
ENT____

7. Please indicate if your child presently or in the past received the following:
   Speech Therapy____
   Occupational Therapy____
   Physical Therapy____
   And length of each therapy.

SPEECH & LANGUAGE HISTORY

1. During the first year, other than crying, would you say he/she was:
   A quiet baby__________ An average baby__________

2. Please describe his/her early vocalizations____
   ____

3. At what age did he/she say his/her first word?______________Examples________________
   ____

4. At what age did he/she name most familiar objects?__________________________________

5. At what age did he/she use two-word combinations like "Want cookie" or "Me out"?_____

6. At what age did he/she use more complete sentences like "I go upstairs"?______________
   Were these easy to understand?____________________

7. Did speech learning ever seem to stop for a period?_____If so, describe________________
   ____
   ____

8. How much does child talk now?____
   How much of this speech can mother understand? All?_____ Most_____ Some_________
   Do other adults understand child?____ Do his/her playmates seem to understand child?___
   Do playmates tease child about his speech?____

9. How do you think child feels about his speech? Unaware of any problem?_____________
   Self-conscious about speech?____________ Other__________________________________

10. What efforts does/did the child make to communicate his/her wants when not understood?
   ____

11. Do parents feel that child stutters or stammers?_____Age of onset__________________

12. Does child's voice sound like other children's voices?_____ If not describe:
   Very soft_____ Very loud_____ Hoarse_____ Nasal_____ Other____________________

SPEECH AND LANGUAGE HISTORY (con't)

13. How easily can child follow directions?____

14. Do you frequently have to repeat instructions?__________________________________

15. How easily (poor, fair, good or excellent) can the child maintain his attention during sitting activities such as: Watching TV___________Reading or looking at pictures___________ Listening to a story____

16. Have parents done anything to help child with speech?_______ If so, explain___________ ____ ____

17. Are there languages, other than English, spoken at home?_____What language?_________ If so, approximately how much of the time in the child's presence?___________________

SCHOOL HISTORY

1. Present grade level________________ Name of School_____________________________ Teacher ____
2. Are there any particular subjects with which he/she has difficulty?____________________ ____
3. Is the child's academic progress up to your expectations?___________________________
4. How does he/she get along with others at school?_________________________________
5. Does child like school?_____Does he/she seem to have many friends at school?_________ Does he/she remember school assignments?_____Does he/she seem to be able to follow directions in school?_____Does teacher complain about his/her behavior in school?______
6. Is your child in any special classroom/school placement or receiving remedial help?______ If so, please describe____

GENERAL BEHAVIORAL HISTORY

1. Check the appropriate adjectives which best describe your child's personality: Outgoing_____Shy_____Anxious_____Easy going_____Agressive_____Stubborn______ Independent_____Dependent_____Other____
2. Does the child become easily frustrated?_____How does he/she respond to frustration?___ ____ How do you handle his/her frustration?____ ____
3. Does child enjoy books (being read to or reading)?________________________________
4. What are his/her dislikes?____ ____

GENERAL BEHAVIORAL HISTORY (con't)

5. Do you feel your child needs much______or little_____discipline?
6. Who is responsible for most of the discipline?___________________________________
7. What methods of discipline do you feel are most effective?__________________________
____
____
8. If there is any additional information which you feel will help us to understand your child and his/her problem better, please describe:______________________________________
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____
____
____
____
____
____