HASA CIRS Interpreting Gateway School
Hearing and Speech-Language Services

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PERSON COMPLETING FORM: _____

RELATIONSHIP TO CHILD:_____ DATE COMPLETED_____

GENERAL INFORMATION

Child's Name _____ Birth Date _____

Address _____

Female ___ Male ___ X ____ Social Security # _____ Race _____

Insurance Carrier _____ Policy Holder_____

Insurance Member ID # _____ Group # _____Policy Holder D.O.B._____

MA # _____Managed Care Organization _____

Claims Address _____

Child Referred by _____

Parent 1/Legal Guardian's Name _____Email _____

Address _____ Employer _____

Work Phone _____ Home Phone _____Cell Phone _____

Parent 2/Legal Guardian's Name _____Email _____

Address _____ Employer _____

Work Phone _____ Home Phone _____Cell Phone _____

Is there court ordered custody? Yes ___ No ___ If yes, who has guardianship? Name _____

Full ___ Partial ___ Temporary ___ Phone _____ Email _____

Social Worker Name _____ Phone _____ Email _____

Attorney Name _____ Phone _____ Email _____

Is there more than one language spoken at home? If so, what is the primary language and what is/are the secondary languages? Yes ___ No ___ If yes_____

What about your child brings you the most joy? _____

_____

_____

_____

_____

DEVELOPMENTAL MILESTONES – Has Your Child Reached the Following Milestones?

	YES	AT WHAT AGE?		YES	AT WHAT AGE?
Imitated/Repeated sounds?			Crawled?		
Said first word?			Stood alone?		
Regularly used single words?			Walked alone?		
Used two-word phrases?			Toilet trained?		
Used sentences?			Fed self?		
Sat alone?			Dressed self?		

EDUCATION

School/Daycare_____ Grade _____

Address _____

Teacher(s) Names(s) _____

School Phone _____Teacher email _____

My child receives: Special Education ___ Speech-Language Therapy___ Occupational Therapy___ Physical Therapy___ Tutoring ___ Other_____.

What is your child's attitude towards school? _____

What are your child's areas of greatest interest in school? _____

Have teachers reported particular concerns about your child's academic performance?_____

DATES OF MOST RECENT EVALUATIONS AND ASSESSMENTS	DATE COMPLETED	PERFORMED BY	CONTACT INFO (phone/email)	OUTCOME
Speech-language evaluation				
Educational assessment				
Audiological (hearing) screening and/or testing				
Psychological/cognitive evaluation				
Occupational/Physical therapy evaluation				

MEDICAL – Check All Diagnoses That Apply

___ADHD
___Allergies
___Anxiety Disorder
___Apraxia
___Asthma
___Autism
___Behavior Difficulties
___Bleeding Problems
___Lead Poisoning
___Diabetes
___Down Syndrome
___Epilepsy/Seizures
___Fragile X Syndrome
___Head Injury
___Hearing Loss
___Hospitalized/Surgeries
___Intellectual Disability/ Development Disorder
___Metabolic Problems
___Seizures
___Vision Loss
___Birth Defects

Is there anything else you want to tell us about your child's medical history?

Pediatrician/Physician _____ Date of Last Evaluation _____

Address _____ Phone _____

Medications_____

Pregnancy and Birth History

Did the pregnancy go to full term? Yes ___ No___ If no, how many weeks early? _____

Were there any complications/maternal health problems with this pregnancy? (infection, drug exposure, hospitalization, toxemia)

_____

Check type of delivery: head first ___ feet first ___ breech ___ cesarean ___

If C-section, pleaexplain_____

Baby's birth weight _____ General health of baby at birth_____ NICU stay? Yes ___ No ___

If yes, please explain_____

Age of baby when discharged home following birth _____

Was your child breast fed ___ or bottle fed ___? Until what age? _____

Were there any problems with breast or bottle-feeding? If so, specify_____

Hearing Health History

Has your child had ear infections? Yes ___ No ___ If yes, how many? _____

Do you think your child has a problem hearing? Yes ___ No___ If yes, why? _____

_____

SPEECH AND LANGUAGE

How does your child greet someone when that person is entering a room? _____

_____

What does your child do when he/she needs help (for example, opening a container, working a toy, reaching for objects)?_____

_____

How does your child attract your attention if you are busy doing something (for example, talking with an adult, preparing a meal)?_____

Does your child like to play social games with you (for example, "peek-a-boo," "I'm gonna get you," etc.) Which ones?

_____

How does your child ask to play these games or keep the game going? _____

_____

Do you feel your child's attention span is normal for his/her age? Yes___ No___ If no, please describe_____

_____

What are some of your child's favorite things – hobbies, games, sports, television shows, etc. _____

_____

I am concerned about my child's (check all that apply):

___Ability to communicate	___Social interaction	___Stuttering
___Academic success	___Speech clarity (production of sounds)	___Understanding of language
___Reading	___Spelling	___Writing

Are there situations in which your child has particular difficulty? Yes___ No ___ If yes, please describe_____

_____

What treatment has your child had for speech and language? What were the results? _____

_____

Has anyone in your family ever had a speech, language, reading, or hearing problem? Yes ___ No ___

If "yes," please explain: _____

_____

OCCUPATIONAL THERAPY – Check all that apply

___My child has poor posture (pot belly, round shoulders, forward spine curve, and/or works w/ head on desk)
___My child tires easily
___My child has problems with skipping, jumping, hopping, running, & walking as compared to others
___My child has difficulty using scissors, pencils, crayons, or fastening clothes
___My child has difficulty with puzzles
___My child dislikes being hugged
___My child craves hugs
___My child loves the swings at the playground
___My child avoids the swings at the playground
___My child omits words and phrases, skips lines, and loses place while reading or copying
___My child is easily distracted
___My child wiggles a lot/can't sit still
___My child can't tolerate change in routine
___My child uses a pacifier past an expected age
___My child puts non-food items in the mouth
___My child is disorganized/ messy
___My child is a slow worker
___My child reverses letters, numbers, words, or phrases when writing
___My child has poor spacing of work on paper
___My child avoids messy activities
___My child's behavior annoys or bothers others
___My child has frequent mood changes
___My child stuffs food into his/her mouth
___My child does not seem to know when his/her face is dirty
___My child has difficulty using utensils
___My child has difficulty with toileting skills
___My child won't eat
___My child only eats certain types of foods
___My child has a family member who has had Occupational Therapy

ADDITIONAL INFORMATION

Thank you for sharing this important information with us. Please include:

- All assessments/evaluations/test reports that may be relevant (if applicable)
- Current IFSP or IEP (if applicable)
- A recent photo of your child
- A document with anything else you want to share with us about your child
- For Educational Programs (Gateway School, Child Care), please include a $35 application fee.

_____

Staff Use Only:
Forwarded to __ Gateway School
__ Clinical Services