



The Hearing and Speech Agency | Harry & Jeanette Weinberg Building | 5900 Metro Drive | Baltimore, MD 21215
(p) 410.318.6780 | MD RELAY 711 | (f) 410.318.6754 | www.hasa.org | hasa@hasa.org

PERSON COMPLETING FORM: _____

RELATIONSHIP TO CHILD: _____ DATE COMPLETED _____

GENERAL INFORMATION

Child's Name _____ Birth Date _____

Address _____

Female ___ Male ___ 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

- | | | |
|--|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Hospitalized/Surgeries |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intellectual Disability/ Development Disorder |
| <input type="checkbox"/> Apraxia | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Metabolic Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Vision Loss |
| <input type="checkbox"/> Behavior Difficulties | <input type="checkbox"/> Head Injury | <input type="checkbox"/> 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, please explain _____

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