CHILD APPLICATION FOR LANGUAGE/SPEECH EVALUATION

WESTERN MICHIGAN UNIVERSITY
Unified Clinics

Western Michigan University Unified Clinics
Charles Van Riper Language, Speech, and Hearing Clinic
1000 Oakland Drive | Kalamazoo, MI 49008 | (269) 387-7059

Client_____
(Last) (First) (Middle)

Birth date_____/_____/_____ Age_____ Gender ◯ Male ◯ Female ◯ Transgender
(month) (day) (year)

Address_____
(Street) (City) (State) (Zip Code)

Parent(s)/Guardian(s)_____ Phone_____

E-Mail Address (if this is a good way to contact you)_____

Parent/Guardian Occupation_____Parent/Guardian Occupation_____

Work Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____ Cell Phone (_____)_____

Can a representative of the clinic leave an identifying message? ◯ Yes ◯ No
If yes, which number(s)?_____

Child's School_____ Grade_____

School Address_____
(Street) (City) (State) (Zip Code)

Form completed by_____ Date_____

Relationship to the client_____

Briefly describe the nature of the problem.

_____

_____

_____

FOR OFFICE USE ONLY File Number_____

Date Received_____

Diagnosis / Supervisor Considerations _____

Scheduled with _____ Date _____Time_____
(supervisor initials)

Rescheduled with _____ Date _____ Time_____
(supervisor initials)

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Referred by (name and address): _____

Reason for referral: ☐ Therapy ☐ Consultation ☐ Recommendations ☐ Other

If Other, please specify: _____

List the agencies or specialists who have seen your client.

Agency / Specialist Address Date of Examination

1. _____
2. _____
3. _____

Health Services Insurance Information (Check all that apply):

◯ Children's Special Health Service ◯ Medicaid ◯ Other Insurance

If Other, please specify:

_____

FAMILY HISTORY

	Name	Age	Speech/Hearing Problem (Indicate type, if known)	Other Information
Father				
Mother				
Sibling(s)				
Other Relatives				

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BIRTH HISTORY

Age of (biological) mother _____ and (biological) father _____ at child's birth.

Weight of child at birth_____ Length at birth_____ Premature ☐ Yes ☐ No How much? _____

Health of mother during pregnancy _____

Describe any problems during pregnancy, including: shocks, accidents, medications, bleeding, toxemia, diabetes, German Measles (Rubella), and other illnesses: _____

_____

How was your baby delivered? ◯ Head first ◯ Feet first ◯ Caesarean operation (please check one)

Were instruments used during delivery? ◯ Yes ◯ No

Were there any problems during pregnancy or delivery, which may be significant? _____

_____

Is there a history of alcohol or other drug use by either parent? ◯ Yes ◯ No

If yes, please explain: _____

_____

DEVELOPMENTAL AND HEALTH HISTORY

How was your child fed as a baby? ◯ Breast-fed ◯ Bottle-fed (please check each that apply)

Were there any feeding problems? ◯ Yes ◯ No If yes, please describe:_____

Was the rate of growth normal? ◯ Yes ◯ No If no, please describe:_____

Give the age (in months) at which the following took place:

First tooth _____ months

Crawling _____ months

Sitting alone _____ months

Walking alone _____ months

Toilet trained all day _____ months

Toilet trained all night _____ months

Has your child had any of the following:

Heart trouble ◯ Yes ◯ No Explain: _____

Emotional difficulty ◯ Yes ◯ No Explain: _____

Cerebral Palsy ◯ Yes ◯ No Explain: _____

Operations ◯ Yes ◯ No Explain: _____
(e.g., tonsils, adenoids, tongue tie, other)

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Which of the following childhood diseases has your child had?
Give the age of your child at the time of illness, whether the illness was serious or mild, whether it was accompanied by a high fever, and any after-effects.

Illness	Age	Serious/Mild	Fever	After Effects	Illness	Age	Serious/Mild	Fever	After Effects
Tonsillitis					Pneumonia				
Pleurisy					Meningitis				
Mumps					Convulsions				
Strep Throat					Enlarged Glands				
Chicken Pox					Rheumatic Fever				
Scarlet Fever					Ear Infections				
Diabetes					Allergies				
Asthma					Influenza				
Measles					Other				

Please list any medications the child is currently taking: _____

_____

_____

PRESENT PHYSICAL CONDITION OF THE CHILD

Current height _____ Current weight _____

Does your child have any physical deformities? ○Yes ○No Describe: _____

_____

Indicate how energetic your child is: ○Not very energetic ○Fairly energetic ○Very energetic

In what activities is your child well coordinated? _____

In what activities is your child awkward? _____

Does your child prefer to use one hand as opposed to the other? ○Yes ○No

If yes, which hand does he/she prefer to use? ○Right hand ○Left hand

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SPEECH AND LANGUAGE DEVELOPMENT

Did your child seem to be delayed in learning to talk? ○Yes ○No

Did an illness or accident seem to stop or cause regression in speech development? ○Yes ○No

Explain: _____

_____

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Was / is a foreign language spoken in the home? ◯ Yes ◯ No Explain: _____

_____

Did / Does your Child:

	Yes	No	Age	Comments
Turn head toward noise				
Babble				
Say single words				
Say two words together				
Combine four or more words together				
Listen to stories read to him/her				
Attend to television for > 10 min.				
Follow one-part directions (e.g., "put it on the bed")				
Follow two-part directions (e.g., "bring me your shoes and shirt")				
Read at grade level				
Write at grade level				

Do you feel your child understands you as well as he / she should? ◯ Yes ◯ No

Indicate on the scale how much you understand your child's communication:

|_____|
0% of the time 50% of the time 100% of the time

My child's communication is understood **most of the time** by: (check all that apply)
◯ Parents ◯ Brothers / Sisters ◯ Other relatives ◯ Playmates ◯ Strangers

HEARING STATUS

Does your child appear to have a hearing problem? ◯ Yes ◯ No Describe: _____

Has your child had a hearing exam recently? ◯ Yes ◯ No If yes, when? _____

Who performed the exam? _____

Please describe the results: _____

Does the child wear hearing aids? ◯ Yes ◯ No

SPEECH AND LANGUAGE INTERVENTION HISTORY

Has your child had previous speech therapy? ◯ Yes ◯ No If yes, when? _____

If yes, where? _____ Therapy provided by whom? _____

Please describe the results / recommendations: _____

_____

_____

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PLAY CHARACTERISTICS

What are your child's favorite play activities or hobbies? _____

_____

Does your child:

	Yes	No	Comments
Play well alone			
Interact during play			
Pretend during play			
Fight frequently with playmates			
Usually take a leader role with friends			
Usually take a follower role with friends			

With whom does your child prefer to play? _____

Why? _____

_____

EDUCATION

Check one of the following to describe your child's performance in school as compared to the performance of his/her peers: ◯Below average ◯Average ◯Above average

What are the highest grades your child has ever received? _____ In which subject(s)? _____

What are the lowest grades the your has ever received? _____ In which subject(s)? _____

Has your child ever repeated or skipped a grade in school? ◯Yes ◯No Explain: _____

_____

Please describe any special education services your child is currently receiving: _____

_____

Does your child enjoy school? ◯Yes ◯No Why? _____

_____

Are there any behaviors for which your child has been punished at school? ◯Yes ◯No

Describe: _____

_____

Has your child ever attended other schools? ◯Yes ◯No If yes, which school(s)? _____

_____

What was the reason for changing schools? _____

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STATEMENT OF THE CHILD'S PROBLEM

Please describe the communication problem in your own words (give examples of the way he/she says words and examples of the types of sentences he/she uses).

Please describe the reactions of the child and others (parents, relatives, friends, etc.) to your child's speech or language.

What do you expect to have answered during your visit to the Charles Van Riper Language, Speech, and Hearing Clinic?