TicTalkToes
SPEECH AND OCCUPATIONAL THERAPY

New Patient Registration

Child's Name: _____ DOB: ____/____/____ ☑ Male ☑ Female

Address: _____City/State:_____ Zip:_____

Parent(s) /Guardian(s) Name(s): _____

Home Phone: _____ Cell Phone:_____

Email address:_____

Emergency Contact Name: _____ Relationship to Child: _____

Emergency Contact Phone #1:_____ Phone #2:_____

What is the best way to contact you for scheduling? ___✔ Email ___✔ Phone

If you have a balance due, how would you like to be billed? ___✔ Email (preferred) ___✔ Mail

Referred By: _____

How did you hear about TicTalkToes Therapy?_____

Family Background

What is the child's primary language? _____

What language(s) does the child speak? _____

Language(s) spoken in the home: _____

Other children in the family (names & ages):

_____

Do any other family members have any developmental delays? ☐ Yes ☐ No

If yes, please state the family member's relationship to the child and describe the difficulties:

_____

_____

Prenatal and Birth History

This child is your: ☑ Biological child ☑ Adopted child ☑ Foster Child

Mother's age at child's birth: _____ Did mother receive routine prenatal care? ☑ Yes ☑ No

Length of pregnancy: _____ Birth weight: ____lbs ____oz Apgar Score _____

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Type of Delivery: ☑ Cesarean ☑ Vaginal ☑ Breech ☑ Feet First

Any unusual conditions that may have affected the pregnancy or birth?

_____

_____

Medical History

Physician's Name: _____ Phone:_____

Physician's Address:_____

Other Physicians/Specialists Involved In Care:

_____

If the child is taking vitamins or medication(s), please list them:

_____

Please list any allergies and how the reactions are managed:

_____

Has the child had any surgeries? If yes, please list the type and when it was completed:

_____

Please indicate if the child has been diagnosed with:

☑ Autism	☐ Down Syndrome	☑ Auditory Processing Disorder	☑ Developmental Delay
☑ Hearing Loss	☑ Cerebral Palsy	☑ Tongue Thrust	☑ Congential Anomaly
☑ Genetic Disorder	☑ Dispraxia	☑ Sensory Disorder	☑ Intellectual Disability

Developmental History

At what approximate age did the child do the following?:

Sit up:	Crawl:	Stand up:
Walk:	Babble:	First word(s):
Put 2 words together:	Sentences:	Tell a Story:
Feed self:	Use utensils:	Dress self:
Drink from an open cup:	Use the toilet:	Ride a tricycle:

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Language

What percentage of the child's speech do you understand? _____%

How well do people outside of the family understand their speech? _____%

How many words does the child say: _____

Please indicate the length of words the child uses in a sentence:

☑ 2 words ☑ 3 words ☑ 4 words ☑ 5+ words

If the child is not using words, how do they primarily communicate?

_____

Does the child have any difficulty with the following:

☑ Attention	☑ Aggression	☑ Anger	☑ Frustration Tolerance
☑ Chewing or eating	☑ Excessive drooling	☑ Answering simple questions	☑ Answering –wh questions
☑ Understanding people	☑ Following directions	☑ Producing speech sounds	☑ Stuttering
☑ Reading	☑ School work	☑ Maintaining eye contact	☑ Transitions
☑ Remembering	☑ Word Retrieval	☑ Telling or retelling a story	☑ Talking in specific settings

Other difficulties not listed above:

_____

Please describe any of the above:

_____

_____

Evaluation

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time:

_____

_____

What are you expecting out of this evaluation / meeting?

_____

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_____

Has the child had a previous speech or language evaluation / treatment? ☑ Yes ☑ No

By whom: _____ When: _____

Describe the results:

_____

_____

At what age did you first notice the problem? _____

How does the child's communication impact the family?

_____

Is the child aware of or frustrated by their communication difficulties?

_____

Educational History

School: _____ Grade _____

Teacher(s): _____

Has an IEP or IFSP been developed for the child? If yes, please include the date of the last written IFSP/IEP: _____

Does your child receive special services? If yes, please describe:

_____

_____

Please provide any other additional information that might be helpful in the evaluation (e.g. their likes or dislikes, their behavior, strategies you might use to help them…etc) and any goals that you would like your child to focus on:

_____

_____

Person completing form: _____

Relationship to Child _____ Date: _____

THANK YOU FOR COMPLETING THIS FORM!

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