4900 Massachusetts Ave NW, Suite 340 Washington, DC 20016

(202) 621-9793 • Care@TriumphTherapeutics.com

Child's name: _____ Child's preferred name: _____

DOB: _____

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

Phone number(s): _____

Who does your child live with? Please provide name(s) and age(s) of any siblings at home.

Does anyone else in the family have a history of speech/language, behavior, learning or physical development concerns? ☐Yes ☐No If yes, please explain:

What languages or dialects are spoken at home? How often and in what settings?

Medical History

Child's primary physician: _____ Address/Phone: _____

Other medical providers: _____ Address/Phone: _____

Type of delivery: ☐Vaginal ☐Cesarean Birth weight _____

Pre-term (< 37 weeks): ☐Yes ☐No If yes, how many weeks: _____

Was your child placed in the Newborn Intensive Care Unit (NICU)? ☐Yes ☐No

If yes, how long? _____

Any feeding or breathing support provided while in the NICU? _____

Were there any pregnancy or delivery complications? ☐Yes ☐No

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Has your child had any significant illnesses or hospitalizations? ☐Yes ☐No If yes, please specify:

Does your child have or is in the process of receiving a medical diagnosis? (e.g., ADHD, ODD, Down Syndrome, GI issues) ☐Yes ☐No If yes, when was this received?

Does your child have any allergies or dietary restrictions? ☐Yes ☐No If yes, please specify:

Is your child on any medications? ☐Yes ☐No If yes, specify:

Does your child have any special equipment or orthotics (ex: eyeglasses, hearing aids, cochlear implants, AAC device etc.)? ☐Yes ☐No If yes, specify:

Are there any concerns regarding hearing? ☐Yes ☐No When and where was the client's hearing most recently tested? Date: _____ Where: _____

Are there any concerns regarding vision ☐Yes ☐No When and where was the client's vision most recently tested? Date: _____ Where: _____

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Speech and Language Developmental History and Current Skills

Please indicate the age at which the following developmental milestones were reached (Please mark N/A if not achieved yet):

Babbling: _____

First words other than mama or dada: _____

First word combinations/phrases (2+ words): _____

Are there concerns regarding:

A. Understanding language: ☐Yes ☐No If yes, specify:

B. Speaking/Talking: ☐Yes ☐No If yes, specify:

C. Social communication/peer interaction: ☐Yes ☐No If yes, specify:

D. Using specific sounds (e.g. "r"): ☐Yes ☐No If yes, specify:

E. Other: ☐Yes ☐No If yes, specify:

Does the client currently demonstrate the following skills:

A. Respond to his/her name: ☐Always ☐Sometimes ☐Never

B. Follow directions: ☐None ☐1-step ☐2-step Example: _____

C. Answer questions: ☐Choice ☐Yes/No ☐"Wh" (e.g., what, where, who)

D. Communicate using primarily:

☐ Body movements and gestures ☐Single words ☐Phrases and sentences

☐Other (e.g., AAC device) (please specify): _____

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E. How many words does the client use? ☐0-20 ☐20-50 ☐50-100 ☐100+

F. What percentage of the client's speech do *you* understand? ___%
What percentage do *others* understand? ___%
G. How does the client interact (e.g., playing, talking) with peers?

Previous Evaluations and Treatment

Has your child received any therapy services (speech therapy, feeding therapy, occupational therapy, physical therapy) including early intervention and/or school-based services? ☐Yes ☐No
If yes, please provide the following information:
Name: _____ Type of specialist: _____
Date(s) of evaluation/treatment: _____
Purpose and results of evaluation/treatment:

Name: _____ Type of specialist: _____
Date(s) of evaluation/treatment: _____
Purpose and results of evaluation/treatment:

Name: _____ Type of specialist: _____
Date(s) of evaluation/treatment: _____
Purpose and results of evaluation/treatment:

Name: _____ Type of specialist: _____
Date(s) of evaluation/treatment: _____
Purpose and results of evaluation/treatment:

Educational History

Is the client currently enrolled in school or Birth-3 Services? ☐No ☐Yes ☐N/A

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School Name: _____ School District: _____
Program or Grade level: _____

Client Interests

What are your child's strengths?

What does your child dislike?

What is your child interested in (i.e. hobbies, favorite toys, etc.)? What motivates your child most?

What are you and/or your child's goals for therapy?

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

Signature:_____ Date:_____

Name printed: _____

Patient Name _____