Holistic Kids
Speech & Language Services
Lucia Pasquel-Lefebvre, MA/CCC-SLP
Speech-Language Pathologist

www.holistickidspeech.com

1415 West NC Hwy. 54
Hamilton Centre, Ste.111
Durham NC, 27707

luciaplef@gmail.com

REGISTRATION FORM

Date: **Referred by:**

Child's Name:

Birth date: **Age:** **Grade:**

School: **Teacher:**

Home Address:

Mother's Name:

Occupation & Employer:

Phone: **(w)** **(cell)**

Email:

Father's Name:

Occupation & Employer:

Phone (h) **(w)** **(cell)**

Email:

Pediatrician(s)

Other services and/or therapies received (ex. OT, SPEECH, PT, PSYCH, Behavioral Intervention)

N/A

Presenting Problems:

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BACKGROUND HISTORY

Date: **Person completing form:**

FAMILY

Father:

Mother:

Siblings: **Age:**

Siblings: **Age:**

Siblings: **Age:**

Step-parent: **Foster parent:**

Parents' marital status:

Is the child adopted: **When?**

Other people living in the home:

Languages spoken with child: English

Family speech/language/learning problems:

Illness/allergies/behavior problems:

Does the child know if there is a problem?

When/How did he/she realize?

Describe your child's personality & behavior:

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Describe your child's typical day and typical week:

What other programs has your child received?

Does the child get along with other children? Play alone?

Favorite toy/game/activity:

Dislikes:

Emotional maturity:

CONCERNS

What are your greatest concerns at this time and what do you see your role is in helping your child?

What therapeutic method/behavior/ have worked best with your child?

How do you manage your child's problem?

Are you currently seeking any other programs or assistance for your child? Please list all alternative therapies, doctors, etc.:

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EDUCATION

List the child's educational, daycare, pre-school history:

Does he/she have an IEP/IFSP? (Please send a copy of DEC 4 & Speech Evaluation if available)

What is school/program performance like?

MEDICAL HISTORY

Child's pediatrician(s)Child's dentist/orthodontist:

Other doctors:

Describe any hospitalizations, ER visits, past and present treatment & medications:

Place and hospital of birth:

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Relevant birth history:

____C-section ___ Natural birth _____Full term ____Premature _____Complications

FEEDING HISTORY

____Breast fed ____Bottle fed ____Feeds self ____Pacifier How long? ___

Difficulties with feeding?

Describe your child's current eating/feeding skills.

Do you have any concerns?

Food allergies, special diets, Reflux, etc.:

_____

_____ none

Child uses: ____Spoon ____Fork ____Bottle ____Sippy cup ___Straw ____Cup ____Pacifier

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Developmental Motor Milestones:

Age turned back to tummy: **Spent time on tummy?**

Age sat up: **Age crawled:** **How well?**

How long?

Age stood up:

Age walked: **How well?**

Age began running: **How well?**

Jumping off both feet: **Jumping off chair, wall:**

Catch/kick a ball:

___Toilet trained **____Dresses self** **____Ties shoes** **_____Independent self-help**

SPEECH/LANGUAGE/ MOTOR HISTORY

Did your child make sounds in the first 6 months?

Describe:

Turn towards people speaking:

Imitated and repeated sounds by 9-12 months:

Describe:

Looked at speaker's face:

Point to request and/or comment:

Follow a person's gaze: **Age _____**

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Combining 2-3 words _____ Age _____

Speaking in complex sentences _____ Age _____

Vocabulary of 10-20 words:

Vocabulary of 20-30 words:

Vocabulary of 30-50 words:

Vocabulary of 50-100 words:

Vocabulary of over 100 words:

Describe your child's language & speech now:

How does your child get his/her needs met?

How does he/she communicate at home, school, etc.?

When did you become concerned about your child's language?

Speech is _____% understandable by strangers

Understandable	**Expression**	**Speech**
___ understands gesture	**___communicates with gestures**	**___not understandable**
___ responds to instructions	**___mostly single words**	**___understood by family only**

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___understands stories **___mostly short phrases** **___understood by most**

___converses at complex level **___speech completely clear**

Describe your child's listening skills?

My child is: **active** **passive** **impulsive** **strong**

clumsy **coordinated** **weak** **anxious**

(highlight all that apply)

Describe your concerns and desired outcomes.

Are you satisfied with the services your child is currently receiving?

What do you hope to accomplish through private therapy?

Does your child need support services such as Occupational therapy, Physical therapy, Neuropsychology, Behavior, Counseling/Mental Health?

Please describe the outcomes you hope for your child through private speech & language therapy services.