



Date: _____

A. WHO IS YOUR CHILD?

Child's name: _____ DOB: _____ Age _____
Address: _____ Phone (work) _____ (Home) _____
City/State/zip code _____ Phone (cell) _____
Dad's Name _____ Mom's Name _____
Brother's Name/Age: _____
Sister's Name/Age: _____
Pet's Name/Type _____ Favorite Food: _____
Favorite Game: _____ Favorite Toy: _____
Favorite Movie: _____ Favorite Book: _____
Is your child at Home: _____ Home Daycare: _____ Preschool _____
BECEP: _____ Kindergarten: _____ Grade School: _____ Tell me about your
child's day to day routine: _____

Is your child in swimming lessons, gymnastics, taekwondo, dance, soccer, basketball,
baseball, other? _____
Who is your child's pediatrician? _____
Most of your medical needs are met through - Medcenter One, St. Alexius, or other _____.

B. Why ARE YOU HERE?

Tell me about your child's speech and language development: _____
How did you find out about the "Scottish Rite Speech Therapy Center for Children"? _____
Has your child been enrolled in a speech and language program before? _____
Where? _____ When? _____
Who saw your child? _____
What does your child think about their own talking? _____
Does your child have relative who received speech or language therapy? _____
Is your child understood by parents? _____
By others? _____ How does your child communicate? Gestures,
pointing, sounds, one word, two and three word sentences, long sentences, other: _____

Scottish Rite Speech Therapy Center for Children
1009 Basin Ave, Bismarck, ND 58504 Phone: 701-258-9132
A Public Supported Local Charity Sponsored by the Scottish Rite Bodies of Freemasonry
A Rite Care Provider



<http://srstcc.glnd.org>

C. HOW IS YOUR CHILD GROWING?

Tell me anything important about the pregnancy with your child (i.e. during pregnancy, during delivery, after delivery, APGAR scores, other) _____

Birth weight? _____ Length? _____ Breast Fed? _____

Bottle Fed? _____ Any sucking or swallowing difficulties? _____

Approximately how old was your child when he/she did the following? rolled over _____

sat up _____ crawled _____ walked _____

said first word _____ drank from cup _____ fed self _____

What hand does your child prefer? _____

D. HOW IS YOUR CHILD'S HEALTH?

Is your child's health good _____ fair _____ poor _____? Does your child wear glasses: _____ Is your child taking any medication? _____ For what reason? _____

How often? _____

What physician is monitoring the medication? _____

Location of physician? _____

E. HOW IS YOUR CHILD'S HEARING?

Does your child currently have tubes in his/her ears? _____

When were tubes placed? _____

Future plans for tubes? _____

Has your child's hearing ever been screened or evaluated? _____

Do you feel your child is hearing properly? _____

Does your child have allergies? _____ If "yes", please explain: _____

ADDITIONAL COMMENTS:

