Welcome to The Language Lounge!

Thank you for choosing The Language Lounge to help meet your child's communication and/or feeding needs. We realize there are many options from which to choose and we appreciate the opportunity to assist you with this important process.

Please take time to fill out as much information as possible regarding your child's developmental history as this information can be vital to the direction of the therapy plan. We understand that these forms can be time consuming; however it is important that we have as much information as possible prior to your first visit so that we may provide the best possible service for your child. If your child has any recent evaluations completed by other health professionals (psychologist, IEP, etc.), please bring copies of these with you or may mail them to us in advance. Completed form packets may be mailed to The Language Lounge 158-01 Crossbay Blvd. Howard Beach, NY 11414. Please feel free to call or e-mail with any questions or concerns regarding this packet. We look forward to meeting you and your child!

Sincerely,
Frangelica Leo, M.S., CCC-SLP, TSSLD
Clinical Director of Related Services
Speech-Language Pathologist

Name:_____

Date of Birth:_____

Address:_____

_____

_____

E-Mail: _____

Phone: _____

Phone2:_____

Parent/Guardian Names:_____

_____

Child lives with both parents? Yes/ No

Primary language spoken in home:_____

Pediatrician: _____

Phone:_____

Referral Source:_____

Previous evaluations (list):

Therapy to date (list):

Describe present concerns:

_____

_____

_____

Has your child have a diagnosis? When?

_____

_____

_____

Has there been any significant change in last six months? Yes/ No

If so, what? _____

_____

_____

_____

Speech and Language Intake

Today's Date:

PRENATAL/BIRTH HISTORY

Full Term: **Yes/ No.** If no, how many weeks?_____

Birth Hospital:_____

Illnesses or accidents during pregnancy:_____

_____

Use of alcohol, tobacco or medications during pregnancy: _____

Birth weight:_____ Delivery: Vaginal___ Cesarean____ Breech____ Feet First____

Other unusual conditions that may have affected pregnancy or birth?_____

_____

MEDICAL HISTORY

Please check if your child has had any of the following (and if so, at what age):

Seizures_____ High fevers_____ Measles_____ Mumps_____ Chicken pox_____

Whooping cough_____ Diphtheria_____ Croup_____Pneumonia_____ Tonsillitis_____

Meningitis_____ Encephalitis_____Rheumatic fever_____ Tuberculosis_____ Sinusitis_____

Chronic colds_____Enlarged glands_____ Thyroid_____ Asthma_____ Heart trouble_____

Explain any checked items here:_____

_____

_____

Are immunizations current? Yes/ No

Current general health:

****Has your child had any earaches/ear infections? Yes/ No

Please explain here:_____

_____

_____

Allergies? (Describe)_____

_____

_____

Any other serious or recurrent illnesses?_____

_____

_____

_____

Any operations? _____

_____

Any accidents? _____

_____

_____

Any medications? (Past)_____

(Current) _____

Vision problems? Treatment: _____

Hearing difficulties? Treatment: _____

Dental problems? Treatment:_____

DEVELOPMENTAL HISTORY

Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed)

sat up alone _____crawled _____ walked _____ toilet trained _____

dressed self _____tied shoes _____ fed self independently _____

Weaned from bottle/breast_____

Is the child left or right handed? _____

Able to use: open cup_____ spoon_____ straw_____

Any difficulty? (Y/N) Swallowing:_____ Chewing:_____ Drinking:_____ Drooling:_____

Food allergies:_____

Favorite Foods:_____

Aversive Foods (if any)_____

Attention span-for self-directed activities:_____

Adult-directed:_____

Eating and sleeping patterns:_____

Does your child respond typically to: Light?_____ Sound?_____ People?_____

Does your child: Play with others? Who?_____

_____

Eat and sleep well?_____ Cry appropriately?_____ Laugh?_____ Smile?_____

Make wants/needs known? _____ How?_____

_____

Does your child show unusual behavior (explain)?_____

_____

LANGUAGE DEVELOPMENT

Age when your child spoke first word: _____ combined words: _____spoke in sentences:____

What was your child's first word(s)? _____

first sentence?_____

Which sounds (if any) are incorrect? _____

How many words can your child say? (list if fewer than fifteen)_____

_____

_____

How long are your child's sentences?_____

Does your child have any difficulty understanding you? (describe)_____

_____

_____

Does your child have difficulty following directions? (describe)_____

_____

_____

Any speech or hearing problems in the immediate or extended family (explain)?_____

_____

_____

SOCIAL DEVELOPMENT

Names and ages of siblings:_____

_____

Other adults living in the home:_____

_____

Moves prior to age 10:_____

_____

Relationship with peers:_____

Number of regular playmates:_____

Ages:_____ Genders:_____

Activities shared with parents and siblings:_____

_____

How does your child handle ***frustration***:_____

_____

conflict:_____

separation:_____

Regular responsibilities:_____

_____

Favorite places:_____

people:_____ toys:_____

snacks:_____ activities:_____

TV programs:_____

What motivates your child most?_____

What discipline methods work best?_____

SCHOOL HISTORY

Child's Current School and Grade:_____

Child's performance educationally:_____

Receiving special services at school:_____

How does your child's teacher describe his/her performance?_____

_____

Has the teacher expressed any concern? If so, what?_____

_____

OTHER

Anything else you would like us to know?_____

_____

_____

_____

CONTACT INFORMATION

At times we may need to contact you for appointment reminders or other concerns. Please complete only the items below that you authorize as a method of contact. Note: Home address, one phone number and one e-mail address are required.

Address: _____

_____

_____

Home Phone:_____ Is it okay to leave message: Yes/ No

Mother's Cell Phone: _____ Is it okay to leave message: Yes/ No

Mother's Work Phone: _____ Is it okay to leave message: Yes/ No

Mother's Email: _____

Father's Cell Phone: _____ Is it okay to leave message: Yes/ No

Father's Work Phone: _____ Is it okay to leave message: Yes/ No

Father's Email: _____

Please select your preferred contact method (one only) for each item listed below:

Appointment Reminders: **Mother's** Email__ Phone __ **Father's** Email__ Phone__ **Home**___

Other Correspondence: **Mother's** Email__ Phone__ **Father's** Email__ Phone__ **Home** ___

Health Policy

Help and cooperation is required in order to maintain a healthy environment. A child must be Temperature-free for 24 hours before returning to therapy. If your child has vomiting and/or diarrhea, he/she should not return to therapy until 24 hours have passed since the last episode of the same. Children will not be seen if any of the following is present:

- Too ill or uncomfortable to function in the therapy setting
- Continual runny nose
- Thick or discolored nasal discharge
- Excessive sneezing or coughing and mucus-producing cough
- An elevated temperature.

Please contact your therapist and cancel session if the above applies to your child.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed. In the event of a court order, only the minimally acceptable amount of information will be revealed. Additionally, if a client files a complaint or lawsuit against anyone affiliated with The Language Lounge; relevant information regarding the client may be disclosed for the purpose of formulating an appropriate defense.

Photocopy Authorization

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed):_____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Patient Signature _____ Date: _____

(if over 18 years old)

For minors:

Legal Guardian Signature: _____ Date: _____

Legal Guardian Signature:_____ Date: _____