

NORTH TEXAS THERAPY INNOVATIONS, P.C.

Plano Clinic
6905 K Avenue, Suite 206
Plano, Texas 75074

Dallas Clinic & Business Office
11880 Greenville Avenue, Ste 100
Dallas, Texas 75243

McKinney Clinic
1800 Harroun Avenue, Suite 100
McKinney, Texas 75069

Main Phone: 214-349-6178

www.ntxtherapyinnovations.com

Fax: 214-575-9898

SPEECH THERAPY INFORMATION PACKET

Once you have completed all forms, please return them along with the following:

- Copy of most recent Speech/Language Therapy evaluation (if you have it).
- Copy of current or most recent IFSP or IEP.
- Copy of medical necessity from your doctor if required by your insurance.
- Copy of any medical evaluations pertaining to the current communication disorder.

PATIENT INFORMATION

Please summarize your primary reason for bringing your child for an evaluation or therapy (i.e. specific concerns and goals).
Is there a specific diagnosis you want ruled out? Include a separate letter telling more about your child if necessary.

MEDICAL INFORMATION

Physician: _____ Phone: _____

Food Allergies: _____

Ear Infections: Y/N Frequency: _____

Tubes: Y/N Dates: _____ Still Present: Y/N

Date of last hearing test: _____ Results: _____

Date of last vision test: _____ Results: _____

Has your child's speech/language development been impacted by hearing difficulties? Y/N

How so? _____

Adenoids/Tonsils Removed: Y/N Dates: _____

History of Reflux: Y/N Still Present: Y/N Reflux Medication: _____

Do you feel your child's feeding development has been impacted by reflux? Y/N

How so? _____

Surgeries: Y/N Date: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Additional information you'd like to share regarding your child's medical history:

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CASE HISTORY

MOST RECENT EVALUATION

Reason for Evaluation: _____
Evaluated By: _____ Date of Evaluation: _____
Results of evaluation: _____

DIAGNOSIS

Diagnosis: _____ Diagnosis Code: _____
Diagnosed By: _____
Date of Diagnosis: _____ Age at Diagnosis: _____

PREVIOUS AND CURRENT TREATMENTS (Speech, OT, ABA, social, biomedical, listening, etc)

Treatment 1 Type: _____ Dates: _____
Provided by: _____ Treating Clinician: _____

Treatment 2 Type: _____ Dates: _____
Provided by: _____ Treating Clinician: _____

Treatment 3 Type: _____ Dates: _____
Provided by: _____ Treating Clinician: _____

Treatment 4 Type: _____ Dates: _____
Provided by: _____ Treating Clinician: _____

Additional information you'd like to share regarding your child's treatments:

PRENATAL AND BIRTH HISTORY

Is the child adopted: Y/N At what age: _____ From what country: _____
Infections/Illness during pregnancy: Y/N
Describe: _____
Abnormal shocks/stress during pregnancy: Y/N
Describe: _____
Did the mother's water break 24 hours before delivery: Y/N
Develop toxemia or high blood pressure: Y/N
Complications during delivery: Y/N
Describe: _____
Type of delivery: Head first Feet first Breech Caesarian
Mother's age at delivery: _____ Length of pregnancy: _____ Birth weight: _____
Number of miscarriages: _____ Premature: Y/N How many weeks: _____
Additional information you'd like to share regarding your child's prenatal and birth history:

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DEVELOPMENTAL HISTORY

Age at independent: Sitting _____ Crawling _____ Standing _____ Walking _____
Feed Self _____ Dress Self _____ Use Toilet _____
Babble _____ Use single words _____ Combine words _____
Name simple objects _____ Use simple questions _____ Engage in conversation _____
Additional information you'd like to share regarding your child's developmental history:

ORAL HYGIENE/FEEDING ISSUES

Date of last dentist visit: _____ Results: _____
Does your child eat foods of varying consistency without difficulty? Y/N
Circle consistency: thick thin chewy crunchy smooth/creamy Other: _____
Circle all that occur during feeding: coughing spitting gagging choking vomit Other: _____
Does your child experience a loss of liquid from the lips when drinking? Y/N
Circle all your child drinks from: bottle sippy cup open cup straw Other: _____
Does your child experience a loss of food when eating from a spoon/fork? Y/N
Was your child bottle or breast fed? _____ How long? _____
Have there ever been any feeding problems? sucking swallowing drooling chewing
Did/does your child suck his/her thumb? Y/N How long? _____
Does your child breathe through his/her mouth or nose: Y/N
Do you have any concerns about how your child's mouth works for speech or eating? Y/N
Describe: _____

ARTICULATION

Circle all that describe your child's speech: Unintelligible Intelligible Soft Loud Hoarse Breathy Nasal
Circle your child's intelligibility: 0% 25% 50% 75% 100%
Can someone who is not familiar with your child understand him/her? Y/N
How does your child react when not understood? _____
What sounds can your child produce? _____
What sounds does your child have difficulty with? _____
Do you have any specific concerns about your child's articulation? Y/N
Describe: _____

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LANGUAGE

Does your child communicate verbally? Y/N

Circle any alternative communication methods: Sign PECS Augmentative Device Other:

Does your child follow directions without cues? Y/N What kind? 1-step 2-step 3+

Length of utterances/sentences: _____

Size of vocabulary: _____

Does your child seem to understand more than s/he can say? Y/N

Describe your child's conversational ability: _____

Do you have any specific concerns about your child's language? Y/N

Describe: _____

Please check all that apply.

SELF-STIMULATORY BEHAVIORS

Does your child show any of the following behaviors?

- Repetitive mannerisms: (ex: hand flapping, flicking, gazing, lining up objects, hoarding objects, toe walking, running back and forth etc.)
- Unusual attachment to objects; Describe: _____
- Repeating previously heard words out of context - echolalia
- Difficulty with transitions or changes in routine
- Unusual interest in the sight, feel, sound, or smell of things
- Unusual preoccupations / obsessions: (anything he or she likes to do repeatedly)
- Verbalizing in a repetitive manner: (ex: "eee" sounds, babbling, screaming, etc.)

Comments: _____

SOCIAL BEHAVIOR

Does your child . . . ?

- Show affection; Describe how: _____
- Play with other children; Describe how: _____
- Play with toys; Describe type of toys and type of play: _____
- Use good eye contact
- Respond to her/his name
- Come to you for comfort
- Respond better to a particular person; To whom: _____
- Greet you when s/he sees you
- Show interest in other people
- Try to involve you in activities
- Try to get involved in activities

Comments: _____

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PRE-ACADEMICS & ACADEMICS

Does your child . . . ?

- Color Ability: _____
- Write Ability: _____
- Draw Ability: _____
- Read Ability: _____
- Cut Ability: _____

Comments: _____

SENSORY

Does your child show sensory differences in the following areas:

- Taste and Smell Describe: _____
- Muscle Tone Describe: _____
- Coordination and Development Describe: _____
- Auditory Describe: _____
- Tactile (Touch) Describe: _____
- Vestibular (Motion) Describe: _____
- Visual Describe: _____

Comments: _____

BEHAVIOR/TEMPERAMENT

Please list any behavioral issues (ex: non-compliance, aggression, tantrums, extreme mood changes, running away, etc.)

When are these behaviors most likely to occur? What are the causes?

How often do these behaviors occur?

What has been the most effective way to deal with these behaviors?

Please list some reinforcers for your child (ex: your child's favorite toys, food, and activities):

Any additional information you'd like to share regarding your child's behavior/temperament:

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FEEDING BEHAVIORS (only fill out if feeding is a concern)

How does your child respond to trying new food? (arguing, gagging, throwing up, crying)

If your child engages in maladaptive behavior (inappropriate behavior) when eating new foods, what has been the most effective way to deal with these behaviors?

How often do you introduce new foods to your child?

Is the frequency of your attempts affected by your child's reaction to new foods? (ex: You don't introduce new foods to avoid having to deal with the behaviors).

What do you think caused your child's limited feeding repertoire? Why do you think there is still one today?

Has your child ever successfully tried new foods? What was the food? How did it happen?

Any additional information you'd like to share regarding your child's feeding behavior:

FOOD HEIRARCHY (only fill out if feeding is a concern)

Preferred (Favorite) Foods: _____

Foods that s/he will eat: _____

Foods s/he used to eat: _____

Unsuccessful foods: _____

Foods never tried: _____

Foods you would like your child to eat: _____
