MARY & ALEXANDER
Laughlin Children's Center
your child's bridge to successful learning

Client History

Child's name: Date:

DOB: Age: Gender: Grade:

Parents' names: Email:

Preferred phone: ☐Home ☐Cell Alternate Phone: ☐Home ☐Cell

Address:

Any custody arrangements? ☐ Yes ☐ No If **yes**, please describe:

Emergency contact: Phone:

How did you hear about us?

Please complete this form as thoroughly as possible to help us better understand your child's development and current issues. Please feel free to indicate in the pertinent information column if you would rather discuss the concern with the clinician.

Family Make-up: Please list members of this child's family and their relationship to this child (e.g., parent(s), stepparent, brother(s), sister(s), stepbrother(s), stepsister(s), grandparent(s) etc.) who reside in the home.

Name	Age	Relationship	Phone	Email

Are languages other than English spoken in the home? ☐ Yes ☐ No

If **yes**, what is the primary language spoken? _____

Please describe the nature of the concern for which you are seeking services._____

_____

_____

_____

Laughlin Children's Center
424 Frederick Avenue, Sewickley, PA 15143
Ph. 412-741.4087 Fax. 412-741-6808

Developmental Information

Pregnancy & Childbirth:

	Pertinent Information	
Describe your pregnancy (normal, full term, premature, # of weeks, health issues)		
Medication taken during pregnancy or labor?	☐ Yes ☐ No	
Any other helpful pregnancy information?	☐ Yes ☐ No	
Describe your child's delivery and birth. ☐typical ☐ induced ☐ Cesarean ☐ breech ☐ premature List any complications:_____		
What was your child's condition at birth? ☐ typical ☐ birth injury/defect ☐ jaundiced ☐ breathing problem ☐ low birth weight ☐ other _____		

Infancy

Did infant have a strong suck?	☐ Yes ☐ No	
Did infant have supervised tummy-time?	☐ Yes ☐ No	
Was infant placed on back to sleep?	☐ Yes ☐ No	
Did infant tend to arch back when held?	☐ Yes ☐ No	

Developmental Milestones

At what age did your child:

Sit unassisted?		Toilet train?	
Crawl?		Feed self?	
Walk?		Dress self?	
Sleep through the night?		Any atypical development?	

Medical History

When was your child last physical?	Doctor:	Results:
When was your child's last vision exam?	Doctor:	Results:
When was your child's last hearing test?	Doctor:	Results:
Any concerns with BMI/Weight? ☐ Yes ☐ No	If ***yes***, were these concerns discussed with your child's primary care physician? ☐ Yes ☐ No	
Current health status: ☐ Good ☐ Okay ☐ Poor		
Any present illness/conditions for which your child is being treated?		
Current medication information:		

If your child's medical history includes any of the following, please check. Please note the age when the incident or illness occurred and any other pertinent information.

Medical Concerns		Age and other pertinent information
Allergies/Asthma	☐ Yes ☐ No	
Childhood disease (chickenpox, measles, mumps, etc.)	☐ Yes ☐ No	
Concussion(s)/Head trauma	☐ Yes ☐ No	
Eye problems (including glasses)	☐ Yes ☐ No	
Ear problems (ear infections, wax buildup, etc.)	☐ Yes ☐ No	
Gastrointestinal issues (reflux, stomach pain)	☐ Yes ☐ No	
Immunization reactions	☐ Yes ☐ No	
Loss of consciousness	☐ Yes ☐ No	
Meningitis or Encephalitis	☐ Yes ☐ No	
Persistent high fever	☐ Yes ☐ No	
Poisoning	☐ Yes ☐ No	
Seizures	☐ Yes ☐ No	
Surgeries (ear tubes, tonsils, adenoids, etc.)	☐ Yes ☐ No	
Hospitalizations & serious illness	☐ Yes ☐ No	

Speech Development

Speech developmental characteristics	Pertinent information
Did your child babble? ☐ Yes ☐ No	
When did your child's first words occur?	
When did your child begin to use two-word sentences?	
Does your child make sounds incorrectly? If **yes**, which sounds? ☐ Yes ☐ No	
How well is your child's speech understood by others?	

At present time, how does your child typically communicate?

Complete sentences ☐ Yes ☐ No	Phrases ☐ Yes ☐ No	Single words ☐ Yes ☐ No
Sounds ☐ Yes ☐ No	Gestures ☐ Yes ☐ No	Other:

How does your child's voice sound?

Normal ☐ Yes ☐ No	Hoarse ☐ Yes ☐ No	Nasal ☐ Yes ☐ No
Explain:		

Does your child understand what is said to him?	☐ Yes ☐ No	Does your child stay on subject in a conversation?	☐ Yes ☐ No
Does your child have difficulty putting words together to form a sentence?	☐ Yes ☐ No	Does your child take turns when talking to someone?	☐ Yes ☐ No
Does your child leave words out of sentences?	☐ Yes ☐ No	Does your child answer questions?	☐ Yes ☐ No
Does your child use correct grammar such as plurals, verb tenses, and pronouns?	☐ Yes ☐ No	Does your child hesitate, "get stuck", repeat, or stutter on sounds or words?	☐ Yes ☐ No
Is your child's rate of speech	☐ Normal	☐ Fast	☐ Slow

Check all that apply to your child		Age and other pertinent information
Difficulty swallowing	☐ Yes ☐ No	
Mouth breather	☐ Yes ☐ No	
Difficulty chewing	☐ Yes ☐ No	
Drooling	☐ Yes ☐ No	
Constant throat clearing	☐ Yes ☐ No	
Did your child ever acquire speech and then slow down or stop talking?	☐ Yes ☐ No	
Does your child have a history of using a word once or several times, and then never using it again? If **yes**, please give examples.	☐ Yes ☐ No	
Did your child go through typical oral exploration (mouthing objects) as infant?	☐ Yes ☐ No	
Does your child respond when spoken to?	☐ Yes ☐ No	
Does your child respond to noises but not speech?	☐ Yes ☐ No	
Is your child extremely sensitive or indifferent to sounds?	☐ Yes ☐ No	
Did or does your child cry less than normal?	☐ Yes ☐ No	
Does your child have a history of frequent ear infections?	☐ Yes ☐ No	
Has your child had a hearing screening/evaluation in the past 6 months? If so, please list dates and results.	☐ Yes ☐ No	
Have any other family members had speech language problems? Indicate the person's relationship to the child and nature of the problem.	☐ Yes ☐ No	

Has your child had a previous speech-language evaluation? ☐ Yes ☐ No

If **yes**, please list date(s) and results. _____

Has your child had previous speech-language therapy? ☐ Yes ☐ No

If **yes**, please list date(s), setting(s), and therapist(s).____

_____

What kind of progress did your child make? _____

_____

_____

Sensory and Motor Information

Please describe your child's independence with the following tasks:

Put on shirt	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Take off shirt	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Take off pants	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Put on pants	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Put on shoes	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Take off shoes	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Tie shoes	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Open buttons	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Close buttons	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Zip a coat	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Use fork and spoon	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Drink from an open cup	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Brush teeth	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do
Wash hands	☐ Independent	☐ Needs some help	☐ Needs a lot of help	☐ Unable to do

Check all that apply to your child		Pertinent Information
Does your child have any difficulty walking, running, sitting, or other large motor skills? If **yes**, please describe.	☐ Yes ☐ No	
Does your child tippy-toe walk?	☐ Yes ☐ No	
Is your child clumsy or does he/she fall a lot?	☐ Yes ☐ No	
Does your child have low body tone?	☐ Yes ☐ No	
Does your child have difficulty with fine motor skills such as stacking, cutting, or handwriting? If **yes**, please describe.	☐ Yes ☐ No	
Is your child sensitive to certain textures of food or clothing? If **yes**, please describe.	☐ Yes ☐ No	
Does your child dislike having substances on his/her hands such as glue or dirt?	☐ Yes ☐ No	
Is your child oversensitive to being touched or dislike being touched?	☐ Yes ☐ No	
Has your child established a hand dominance?	☐ Yes ☐ No	
Does your child have difficulty with handwriting and copying tasks?	☐ Yes ☐ No	
Does your child print legibly?	☐ Yes ☐ No	

Check all that apply regarding your child:

☐ dislikes washing his/her face or hair	☐ does not demonstrate caution
☐ dislikes haircuts	☐ puts things in his/her mouth besides food
☐ spends too little time or too much time brushing his/her teeth	☐ chews on his/her clothes
☐ tires easily	

Current Behavioral/Emotional Information

For children **ages 4 to 18**—please check if the behavior describes your child:

Behavior		Pertinent information
Nervousness, strong fears, face twitches	☐ Yes ☐ No	
Difficulty sleeping	☐ Yes ☐ No	
Nightmares	☐ Yes ☐ No	
Headaches	☐ Yes ☐ No	
Stomachaches	☐ Yes ☐ No	
Sleepwalking	☐ Yes ☐ No	
Shyness	☐ Yes ☐ No	
Excitability	☐ Yes ☐ No	
Easily discouraged	☐ Yes ☐ No	
Self-harm	☐ Yes ☐ No	
Suicidal thoughts	☐ Yes ☐ No	
Fainting	☐ Yes ☐ No	
Tongue sucking	☐ Yes ☐ No	
Thumb sucking	☐ Yes ☐ No	
Bedwetting	☐ Yes ☐ No	
Soiling	☐ Yes ☐ No	
Constipation	☐ Yes ☐ No	
Face twitching	☐ Yes ☐ No	
Strong fears	☐ Yes ☐ No	
Strong hates	☐ Yes ☐ No	
Unusual food habits	☐ Yes ☐ No	
Preference for younger children	☐ Yes ☐ No	
Preference for older children	☐ Yes ☐ No	
Head banging	☐ Yes ☐ No	
Temper tantrums	☐ Yes ☐ No	
Whining	☐ Yes ☐ No	
Stealing	☐ Yes ☐ No	
Running away	☐ Yes ☐ No	
Destructiveness	☐ Yes ☐ No	
Hurting pets	☐ Yes ☐ No	
Rudeness	☐ Yes ☐ No	
Fighting	☐ Yes ☐ No	
Jealousy	☐ Yes ☐ No	
Selfishness	☐ Yes ☐ No	
Lying	☐ Yes ☐ No	
History of attention difficulties in parents/ relatives?	☐ Yes ☐ No	

	Pertinent information
Please describe family harmony (getting along together).	
Please describe significant separations of child (give dates, reason, and duration) from main caretaker (mom or dad, grandparent) or grief due to a family member's death/injury/illness.	
Has your child experienced any adverse childhood experiences or traumatic events? If **yes,** please explain.	
Does your child repeatedly talk about or seem to be preoccupied by anything such as an event that was upsetting to him or a fear (storms, animals, safety, etc.?) If **yes,** please explain.	

Educational Background

Please complete section for your child's current age/grade.

For children ages 2 to 5:

Does your child attend preschool or daycare? ☐ Yes ☐ No

If **yes**, Name of facility and number of times/hours per week: _____

Please describe his/ her adjustment (e.g., behavior, separation, attention span, activity level, interaction with others, etc.):_____

_____

For children kindergarten and above:

School district you reside in: _____ School name: _____ Grade:_____

Other schools attended:_____Grades:_____

Other schools attended:_____Grades:_____

Homeschooled:_____

Please comment on your child's experiences and attitudes toward school._____

_____

Has your child ever repeated a grade? ☐ Yes ☐ No If **yes**, which grade? _____

Explain the reason. _____

Is there a history of reading or math difficulties in parents, siblings or close relatives? ☐ Yes ☐ No

If **yes**, please describe: _____

Has your child ever had any educational testing done inside/outside of the school? ☐ Yes ☐ No

If **yes**, when and by whom?_____

What were the results? _____

Does your child have support services? ☐ Yes ☐ No If **yes**, what services? _____

Does your child have an IEP? ☐ Yes ☐ No If **yes**, what is the IEP for? _____

_____

_____

Current School Performance

My child has difficulty with:

Reading		Pertinent information
learning names of letters.	☐ Yes ☐ No	
learning sounds of letters.	☐ Yes ☐ No	
with rhyming words.	☐ Yes ☐ No	
naming sounds within words.	☐ Yes ☐ No	
blending sounds together.	☐ Yes ☐ No	
sounding out unfamiliar words.	☐ Yes ☐ No	
reading without errors.	☐ Yes ☐ No	
reading without hesitation.	☐ Yes ☐ No	
reading at an appropriate rate.	☐ Yes ☐ No	
understanding what he/she has read.	☐ Yes ☐ No	
Spelling		
memorizing words for spelling tests.	☐ Yes ☐ No	
spelling words correctly in written work.	☐ Yes ☐ No	
Writing/Written expression		
with handwriting and copying tasks.	☐ Yes ☐ No	
with writing legibly.	☐ Yes ☐ No	
with expressing ideas in writing.	☐ Yes ☐ No	
with writing mechanics (capitalization, organization, punctuation, spelling).	☐ Yes ☐ No	
Math		
learning names of numbers.	☐ Yes ☐ No	
understanding number sequence.	☐ Yes ☐ No	
correlating numerals with quantity.	☐ Yes ☐ No	
understanding number values.	☐ Yes ☐ No	
counting forward to 18 and back to1.	☐ Yes ☐ No	
skip counting.	☐ Yes ☐ No	
understanding mathematical operations and signs.	☐ Yes ☐ No	
learning math facts.	☐ Yes ☐ No	
understanding math word problems.	☐ Yes ☐ No	
remembering and applying	☐ Yes ☐ No	

mathematical procedures .		
doing mental math.	☐ Yes ☐ No	
Studying/Organization		
remembering information.	☐ Yes ☐ No	
maintaining attention and sustaining focus.	☐ Yes ☐ No	
having required materials for homework.	☐ Yes ☐ No	
doing homework independently.	☐ Yes ☐ No	
turning in homework on time.	☐ Yes ☐ No	
completing a project.	☐ Yes ☐ No	
organizing materials.	☐ Yes ☐ No	
studying for tests.	☐ Yes ☐ No	
balancing time for all activities.	☐ Yes ☐ No	

Rate your child's school achievement:

Subject	Failing	Below Avg.	Average	Above Avg.	Pertinent information
Reading	☐	☐	☐	☐	
Spelling	☐	☐	☐	☐	
Handwriting	☐	☐	☐	☐	
Written expression	☐	☐	☐	☐	
Math	☐	☐	☐	☐	

Please describe any other educational concerns. _____

_____

_____

_____

I give my consent to share this information with the other Laughlin Center Departments while my child is receiving services if additional services or consultations are needed.

_____

Parent or guardian signature Date

Laughlin Children's Center will not release records of your child without your written permission.