Santa Rosa RiteCare® Childhood Language Center

"Language/Literacy Achievers" Program Application (3-18 years of age)

DEVELOPMENTAL QUESTIONNAIRE

Please Fill Out Completely

Date:_____
Child's Name:_____
Age:_____ DOB:_____ Sex: M ☐ or F ☐
School:_____
Home Address:_____ City:_____ Zip_____
Email:_____
Home or Primary Phone#:_____ Cell:_____ Work:_____
Parent or Caregivers Name(s):_____
Child's Primary Language:_____
What are you concerned about?
PDD/Autism ☐ Asperger's Syndrome ☐ Vision ☐ Hearing ☐
Developmental Delay ☐ Learning Disabilities ☐ Speech & Language Delays ☐

Family Information History

Parents

Mother's Name:_____ Age:_____
Occupation/Employer:_____
Phone:_____ Birthplace:_____

Father's Name:_____ Age:_____
Occupation/Employer:_____
Phone:_____ Birthplace:_____

Parents are: Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Deceased ☐

Primary Caregiver (if other than named parent above):_____
Relationship to the Child:_____ Phone:_____
Birthplace:_____ Age:_____

Does family have a history of speech and language difficulties? Yes ☐ No ☐
If yes, please explain:

_____

_____

Siblings

05/2017

Name	Age	Sex

Do siblings have a history of speech and language difficulties? Yes ☐ No ☐
If yes, please explain:_____

_____

Health Information History

At Present

Describe your child's general health:_____

_____

Has your child received all required immunizations for his/her age? Yes ☐ No ☐
*All children must be up to date on all required immunizations prior to enrollment.
Does your child:
1.) Wear glasses? Yes ☐ No ☐
2.) Have allergies? Yes ☐ No ☐ (list)_____
3.) Currently sees a physician for conditions other than regular check-up? Explain:

_____

_____

4.) Takes Medications? Yes ☐ No ☐

Medication	To Treat What?	Frequency	Side Effects

5.) Seems to be emotionally and mentally healthy? Yes ☐ No ☐
If no, explain:_____
6.) Sees an orthodontist? Yes ☐ No ☐ For what reason?_____
7.) Have any feeding/swallowing difficulties? Yes ☐ No ☐ Explain:_____

Birth

Is the child adopted? Yes ☐ No ☐
Length of Pregnancy:_____ Was the delivery normal? Yes ☐ No ☐
If no, explain:_____
Was the mother's health good during the pregnancy? Yes ☐ No ☐
If no, explain:_____
During pregnancy, did the mother :
Smoke? Yes ☐ No ☐ Drink Alcohol? Yes ☐ No ☐ Use Drugs? Yes ☐ No ☐
Child's weight/condition at birth:_____

Development

Does your child have a history of ear infections? Yes ☐ No ☐
If yes: Frequency_____
At what age did your child reach these developmental milestones?
Sat up alone_____ Dressed Self_____ Crawled_____
Walked Alone_____ Toilet Trained_____
Motor coordination is: Excellent ☐ Good ☐ Poor ☐

Behavior/Discipline

Does your child have playmates in the neighborhood? Yes ☐ No ☐
Seems to be a leader? ☐ Or a follower? ☐
Prefer to play with people? ☐ Or things? ☐
What seems to motivate your child?_____
What pleases you most about your child's behavior?_____
_____
What bothers you most about your child's behavior? _____
_____
Method of discipline used?_____
How often does your child need to be disciplined?_____
Discipline has been: Strict ☐ Lenient ☐ Inconsistent ☐ Adequate ☐

Communication Development

Age of first words:_____ Age of first sentences:_____
When did your child's speech/language first concern you?
_____

How has the family attempted to improve the child's communication?

_____

What do you think may have caused the problem?

_____

Has your child been seen or evaluated by:

Speech-Language Pathologist? Yes ☐ No ☐
Name:_____ Agency:_____ Date:_____
Developmental Psychologist? Yes ☐ No ☐
Name:_____ Agency:_____ Date:_____
Developmental Pediatrician? Yes ☐ No ☐
Name:_____ Agency:_____ Date:_____
Occupational Therapist? Yes ☐ No ☐
Name:_____ Agency:_____ Date:_____

PLEASE ATTACH ANY OTHER SPEECH AND LANGUAGE AND/OR MEDICAL REPORTS THAT MAY BE PERTINENT TO YOUR CHILD'S THERAPY HERE AT THE CENTER

****PLEASE ATTACH DOCUMENTATION OF ALL VACCINATIONS IN THE FORM OF YOUR CHILD'S IMMUNIZATION RECORD OR A SIGNED STATEMENT FROM A MEDICAL DOCTOR****

IN ORDER FOR YOUR APPLICATION TO BE COMPLETE, YOU MUST PROVIDE ALL PREVIOUS TEST SCORES, SUCH AS ACHEIVEMENT TEST

Literacy/Learning Disabilities/Dyslexia

Complete this form <u>ONLY</u> if you are requesting an evaluation or therapy for learning disabilities/dyslexia!

Name:_____ DOB:_____

Does your child know how to speak English? Yes ☐ No ☐

Which of these or you most concerned about? (Please check all that apply)

Reading		Hyperactivity	
Spelling		Social Skills	
Math		Sadness	
Handwriting		Worry	
Writing Stories		Moodiness	
Distractibility		Argues	
Concentration		Suicidal Tendencies	
Focus		Gets in Trouble	
Temper/Anger		Other (please list below)	
Other:			

Have you ever been to a school meeting for your child to receive help? Yes ☐ No ☐

Does your child receive special help at school or has he/she in the past? Yes ☐ No ☐

Please check all that apply:

Tutoring ☐ Resource Specialist ☐ Speech ☐ ESL ☐ Inclusion ☐ O.T.R. ☐

Is there a plan for your child to be tested by the school or another private agency?

Yes ☐ No ☐

Has your child seen a doctor about attention or behavioral problems? Yes ☐ No ☐

Has your child taken medicine to help with attention or behavioral problems?

Yes ☐ No ☐ If, yes please list the medicine and the age your child first started the medicine:_____

_____

Does your child any medical diagnoses? (Please check all that apply)

ADHD/ADD		Bipolar Disorder	
Allergies		Cerebral Palsy	
Autism		Cleft Palette/Cleft Lip	
Conduct Disorder		Depression	
Developmental Delay		Obsessive Compulsive Disorder	
Fragile X		Fetal Alcohol Syndrome	
PDD		Seizure Disorder	
Other:			

IN ORDER FOR YOUR APPLICATION TO BE COMPLETE, YOU MUST PROVIDE ALL PREVIOUS TEST SCORES, SUCH AS ACHEIVEMENT TESTS

Permission to Confer with Outside Professionals

Client's Name:_____ DOB: _____

I hereby give permission to the Santa Rosa RiteCare® Childhood Language Center to contact other professionals working with my child. The purpose of this contact will be to share information in order to make treatment as integrated as possible. This permission will remain in effect until my child is no longer receiving services from the RiteCare® Center.

Please identify other professionals/agencies providing services to your child:

- ☐ Speech Agencies (Please Specify)_____
- ☐ Hospital (Name of Contract)_____
- ☐ Private Speech Therapist (Name)_____
- ☐ Social Worker/Psychologist, etc. (Name)_____
- ☐ Regional Center (Name of Contact)_____
- ☐ School: Therapist:_____ Teacher:_____

Signature:_____ Date:_____

Authorization for Release of Information (Outgoing)

Client's Name:_____ DOB: _____
I, the undersigned, herby authorize the Santa Rosa RiteCare® Childhood Language Center to provide information from the records of the above-named client to the following person or agency:

Name:_____
Agency:_____
Address:_____ City:_____ Zip:_____
Function of person or agency to which disclosure is to be made:_____
_____

This information may be disclosed to the following:

- ☐ Physician(s)
- ☐ School District
- ☐ Other:_____

The undersigned may withdraw this authorization upon written notice received by the Santa Rosa RiteCare® Childhood Language Center at any time prior to the release of the information. **This permission will remain in effect until the client is no longer receiving services from the RiteCare® Center**.

A copy of this authorization is available for the personal records of the undersigned.

Signature:_____ Date:_____
Relationship to Client:_____

Consent for Release of Information (Incoming)

The undersigned hereby authorizes :_____
Person/Agency
_____, and any institution, school, physician,
Address
or professional to release information relating to the treatment and/or education of

_____ _____
Clients' Name Date of Birth

_____ , to the Santa Rosa RiteCare®
Client's Address
Childhood Language Center and the institution, agency, school, physician, or professional. This authorization extends to the furnishing of copies of all or any part or parts of the records pertaining to the above client.

You are hereby released from all legal liability that may arise by providing any information requested from the Santa Rosa RiteCare® Language Center.

This permission will remain in effect until the client is no longer receiving services from the Santa Rosa RiteCare® Language Center.

Signature:_____ Date:_____
Relationship to Client:_____

Speech Services

Date:_____

Child's Name:_____ DOB:_____
Parent's Name:_____ Phone:_____
Address:_____

1. Is your child receiving speech therapy in school? Yes ☐ No ☐
2. If you answered YES, please include the following information:
    a. Name of therapist:_____
    b. School:_____
    c. Number of times per week:_____
    d. Length of therapy sessions:_____
    e. Individual or group therapy:_____
    f. If group, how many children in the group:_____

3. Does your child receive any speech therapy other than in the schools? Yes ☐ No ☐
4. If you answered YES, please provide the following information:
    a. Agency providing therapy:_____
    b. Name of therapist:_____
    c. Number of times per week:_____
    d. Length of therapy sessions:_____
    e. Individual or group therapy:_____
    f. If group, how many children in the group:_____

**It is important that you list all speech therapy services that your child presently receives to avoid any complications at a later date.

Authorization Form

____ I hereby give permission for a speech and language evaluation to be performed at the Santa Rosa RiteCare® Childhood Language Center. I understand the purpose of this evaluation is to determine the nature and extend of my child's speech/literacy and/or language difficulties. This evaluation will be performed by a certified, licensed speech-language pathologist. All reports regarding this evaluation will be confidential and remain in the Center files unless otherwise requested by me.

____ I hereby give permission for speech-language therapy to be provided to my child at the Santa Rosa RiteCare® Childhood Language Center. This therapy shall be provided by a certified, licensed speech-language pathologist or a graduate student clinician who is under the supervision of a certified licensed speech-language pathologist

Signature:_____ Date:_____
Relationship to Client:_____
Client's Name:_____