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

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

****Effective 11/30/2020, the immunization protocol is suspended. When we begin to meet again in person, the immunization protocol will be back in effect. ****

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

Complete this form ONLY 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

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:____

05/2017

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.

____ 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:____