Jewish Family Service

# SERVICES FOR CHILDREN & FAMILIES

**Request For Services** (check which apply):

☐ **SPEECH AND LANGUAGE**
Sheryl B. Ambers, MS, CCC-SLP
469-206-1632
sambers@jfsdallas.org

☐ **OCCUPATIONAL THERAPY (OT)**
Audrey Osburn, OTR
469-206-1683
aosburn@jfsdallas.org

☑ **FAMILY SCHOOL LIAISON**
Joanna Kirschbaum, LMSW
972-437-6993 x270
jkirschbaum@jfsdallas.org

Adina Wachsman, MS Ed
469-206-1679
awachsman@jfsdallas.org

Today's Date:____/____/____ **JFS Main Line: 972-437-9950**

## CLIENT INFORMATION

Name: _____DOB ___/___/_____ Sex: F ☐ M ☐

Referred by: _____ Information completed by: _____

## GUARDIAN AND CONTACT INFORMATION

1. RELATIONSHIP TO CHILD: _____ Emergency Contact? Yes ☐ No ☐

Name: _____Phone: (H/W/C) _____(H/W/C) _____

Email: _____Okay to email? Y ☐ N ☐ Check Often? Y ☑ N ☑

2. RELATIONSHIP TO CHILD: _____ Emergency Contact? Yes ☐ No ☐

Name: _____Phone: (H/W/C) _____(H/W/C) _____

Email: _____Okay to email? Y ☑ N ☐ Check Often? Y ☐ N ☐

Briefly, describe your reason for this request today, why you are concerned:

_____

_____

_____

_____

## SECTION I - SCHOOLS

1. SCHOOL: _____ Child's Current Grade:_____
   Teacher's Name: _____
   Teacher's Phone Number (s): _____
   Teacher's Email: _____
2. Has he/she repeated any grades? Yes ☑ No ☐ If yes, which grades? _____
   What grades is he/she now making in…
   Reading? _____ Spelling? _____ Math? _____ Writing? _____ Conduct? _____
3. Has your child had any special problems in school? Yes ☑ No ☐
   If so, please explain: _____

_____

_____

***CONSENT TO RELEASE INFORMATION:***

*I,* _____ *, hereby authorize Jewish Family Service to*
Name of Parent

*contact the above teacher to discuss my child,* _____*'s speech, language or OT needs,*
Name of Child

*progress and therapeutic classroom suggestions.*

_____
Signature of Parent or Guardian Date

**JEWISH FAMILY SERVICE**
**of Greater Dallas**

**Name:** _____
**School:** _____

## SECTION II – BIRTH

1. Did the mother have any illnesses during her pregnancy with your child? Yes ☑ No ☑
   Was the mother R.H. negative? Yes ☑ No ☑
   Take any medications other than vitamins? Yes ☐ No ☑
   Almost have a miscarriage? Yes ☐ No ☐
   If yes to any of these, please explain _____
   _____
   Has the mother had any previous miscarriages? Yes ☑ No ☐
2. Length of pregnancy:_____ Indicate type of birth: Vaginal ☑ Caesarean ☑
   Was the labor very long or especially short? Yes ☑ No ☑ If yes, est. time:_____
   Birth weight:_____ Was the birth of your child normal? Yes ☑ No ☑
   If no, please explain _____
   _____
3. Did your child have any trouble breathing after birth? Yes ☑ No ☑
   Did your child look blue or yellow after birth? Yes ☑ No ☑
   Did your child come home from the hospital with the mother? Yes ☑ No ☑
   If no, please explain _____
   _____
4. Please describe any conditions concerning pregnancy or birth of your child which were not normal:
   _____

## SECTION III – PHYSICAL DEVELOPMENT

1. At what age did your child do the following?
   Sit Alone? _____ Crawl? _____ Walk Alone?_____
   Feed Self? _____ Dress Self? _____ Bathe? _____

   Achieve bladder control? _____ Day?_____ Night? _____
   Achieve bowel control? _____ Day?_____ Night? _____
2. Did your child achieve these skills at about the same rate as other children? Yes ☑ No ☑
   If no, please explain _____
   _____
3. Was your child breastfed? Yes ☑ No ☑
4. Describe any feeding problems, if any _____
   _____
5. Is your child a "picky" or "fussy" eater now? Yes ☑ No ☑
   Does he/she seem to have any trouble swallowing? Yes ☑ No ☑
   Chewing? Yes ☑ No ☑
   Foods he/she avoids: _____
6. Does your child still drool? Yes ☑ No ☑
   If so, when? _____
   _____

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**Name:** _____
**School:** _____

## SECTION IV – MEDICAL

1. Child's Doctor or Pediatrician: _____
   Address: _____
   _____
   Phone: _____
2. Additional doctors (such as ENT, Neurologist, Psychologist, Psychiatrist, etc.) _____
   _____
   _____
3. Please list any illnesses, injuries, operations on your child or previous diagnoses given to your child:

| Type | Age | Severity of Condition | Treatment | Complications (fever?) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

4. Does your child have any allergies? Yes ☑ No ☑
   If yes, please list and describe treatment, reaction and severity _____
   _____
   _____
   List any food sensitivities or preferences: _____
5. About how many colds does your child have per year? ____
   Is your child in good physical health now? Yes ☑ No ☑
   If no, please describe_____
   _____
6. Please list the current medications that your child is taking:

| Name | Purpose | Dosage | Length of time to be taken |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

### HEARING

Has your child had his/her hearing tested? Yes ☑ No ☑
If so, by whom, when? _____
_____
Results _____
_____
Does he/she wear a hearing aid? Yes ☑ No ☑
If so, how long? _____
Is there a reason to believe that he/she might have a hearing problem, if so, why? _____
_____
_____

### VISION

Has your child has his/her eyes examined? Yes ☑ No ☑
If so, by whom, when? _____
_____
Results _____
_____
Does he/she wear glasses? Yes ☑ No ☑
If so, how long? _____
Is there a reason to believe that he/she might have a vision problem, if so, why? _____
_____
_____

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**School:** _____

## SECTION V – FAMILY

1. Parental status, please indicate: Married ☑ Separated ☑ Divorced ☑
2. If so, how old was your child when this occurred? _____
   Who has custody? Please detail _____
3. Is your child adopted? Yes ☑ No ☑
   If so, how old was your child when he/she was adopted? _____
4. Who is your child's primary caretaker? Mother ☑ Father ☑
   Other, please specify: _____
5. Are there others living in the home besides parents and children? Please list:_____
   _____
6. Are there relatives on either side who have suffered from the following (please check all that apply):
   Cleft lip or palate? ____ Trouble speaking or delayed speech? _____
   Trouble hearing or deafness? ____ Trouble learning in school? _____
   Failed 2 or more grades? ____ Dropped out of school due to failure? _____
   Problems learning to read? _____ Mental Retardation? _____
   Epilepsy? _____ Cerebral Palsy? _____
   Autism Spectrum Disorders? _____ Pervasive Developmental Disorders? ___
   Other illnesses of note: _____

## SECTION VI – SPEECH

1. Was any foreign language taught to the child or spoken at home? Yes ☑ No ☑
   If yes, what language? _____
2. How old was your child when he began to say words? _____ mo/yrs
   Put 2 or 3 words together in a phrase (such as "go bye bye") _____mo/yrs
3. Do you feel speech developed at a normal age and rate compared to other children? Yes ☑ No ☑
   If no, describe _____
4. Does your child's voice sound like other children's voices? Yes ☑ No ☑ Not sure ☑
   If no, describe (check all that apply)… Very soft ☑ Very loud ☑ Hoarse ☑ Nasal ☑
   Other_____
5. How much of your child's speech can the family understand (check one)?
   All ☑ Most ☑ Some ☑ Very Little ☑
   How much of your child's speech can other adults or strangers understand (check one)?
   All ☑ Most ☑ Some ☑ Very Little ☑
6. If your child has a speech problem, please complete the following:
   a) At what age was a speech problem first noticed? _____ yrs old
   b) Do you consider this problem to be (check one): Severe ☑ Moderate ☑ Mild ☑
   c) Does your child stutter or stammer? Yes ☑ No ☑ Not sure ☑
7. Has your child ever been evaluated by any speech or hearing specialists in the past? Yes ☑ No ☑
   If yes, who and from what organization, when? _____
   _____
   Describe the results: _____
   _____
8. Has your child had speech therapy in the past? Yes ☑ No ☑
   If yes, with whom, name and location? _____
   _____

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## SECTION VI – DAILY ACTIVITIES

1. What are your child's favorite activities: _____
_____
_____
2. What are your child's favorite games or toys: _____
_____
_____
3. Does your child play actively with other children? Yes ☑ No ☑
Does your child have any close friends? Yes ☑ No ☑
How does your child interact with others ( eg. shy, friendly, aggressive, takes turns, etc.)? _____
_____
4. Are there any activities at school or home your child has difficulty participating in?
Feeding ☑ Sleeping ☑ Playing ☑ Coordination ☑ Writing/Coloring ☑
Other, please specify:_____
5. Do certain situations or activities upset your child? Yes ☑ No ☑
If so, please explain: _____
_____
6. Please describe your child's typical activity level?
Mellow ☑ Calm ☑ Cautious ☑ Easily Excited ☑ Always Very Active ☑ Trouble Sitting Still ☑
Do any particular tasks raise or lower their typical activity level (eg. very active after recess, sleepy after bathing, etc.)? _____
7. Does your child care for himself (eg. dressing, eating, etc.) like other children his age? Yes ☑ No ☑
8. Does your child have trouble sleeping? Yes ☑ No ☑
Have frequent nightmares? Yes ☑ No ☑
Have unusual or strong fears? Yes ☑ No ☑
9. Describe any behavior which is a problem at home: _____
_____
_____
_____
_____
10. Has your child ever been evaluated by an occupational therapist in the past? Yes ☑ No ☑
If yes, who and from what organization, when? _____
_____
Describe the results: _____
_____
11. Has your child had occupational therapy in the past? Yes ☑ No ☑
If yes, with whom, name and location? _____
_____

**ADDITIONAL COMMENTS**: (Is there anything else you'd like us to know?)
_____
_____
_____