Jewish Family Service

SERVICES FOR CHILDREN & FAMILIES

Request For Services (check which apply):

☐ **SPEECH AND LANGUAGE**
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☐ **OCCUPATIONAL THERAPY**
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☐ **INTERVENTION SPECIALIST**
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CLIENT INFORMATION Today's Date: ___/___/___

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

v. 5-13

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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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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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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Name: _____
School: _____

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 additional that you'd like us to know...)

_____