

LOUISIANA SCOTTISH RITE FOUNDATION
Speech, Language & Hearing Centers
P. O. Box 64
Shreveport, Louisiana 71161 - 0064
Telephone: (318) 221 - 9713

In Conjunction With:
Mollie E. Webb Speech &
Hearing Center

CONFIDENTIAL PARENTAL REPORT

In order to plan an evaluation for your child certain information is requested. Please provide to the best of your ability and knowledge. If you have difficulty remembering dates, please provide a date where possible. All of the information is confidential and will not be released without your written consent.

Name of Child: _____ Date: _____

Age: _____ Birthdate: _____ Sex: _____ Phone: (H) _____ (W) _____

Address: _____ City _____ State: _____

Who referred you for evaluation? _____

Why are you requesting an evaluation? _____

Has the child received previous speech/language evaluation? _____ Where? _____

When _____

Father's Name: _____ Mother's Name: _____

If guardian (s) is not natural parent, please give name (s) and relationship (s): _____

Father's Occupation: _____ Level of Education _____

Mother's Occupation: _____ Level of Education _____

Name and age of other children:

Name and relation of other people living in the home: _____

Are others involved in the child's care? _____ If so, Who? _____

Is any language other than English spoken in the home? _____

Name of person completing the report _____

BIRTH HISTORY: Did any abnormal factors influence this pregnancy? _____

Length of pregnancy: _____ Birthweight: _____ Were there any difficulties during labor and/or delivery? _____

Condition at birth: _____

MEDICAL HISTORY: Present state of health: _____

Under Medical Treatment for: _____

Has child ever had serious illnesses or accidents? _____

High fevers _____ When _____ Type of illness _____

Ear infections or draining ears? _____ When _____

Has child ever been hospitalized? _____ When _____ Type of problem _____

Is the child currently on medication? _____ If so, what kind? _____

Comments: _____

DEVELOPMENTAL HISTORY: State AGE when child first: Sat alone _____ Crawled _____

Walked alone _____, Babbled _____, Said first word _____, Could string words together _____

Comments: _____

SPEECH: What is the child's present communication performance:

Attends readily to speech of others _____, Uses speech to communicate _____ Hesitates and repeats sounds or words _____. Is not understood by people outside the family _____, Gestures much of the time _____, Makes no attempt to communicate _____, Is teased about his speech by others _____. Has the child received speech therapy? _____; Where? _____, When? _____

HEARING: Did child seem to hear as an infant? _____. Has there every been any doubt about his ability to hear? _____ Has child ever been seen for a hearing evaluation? _____ If so, when _____, where _____

EDUCATIONAL DATA:

Is the child in a day care center? ___ Where? _____ Amount of time spent in facility per week? _____

Does the child attend: Kindergarten (4 year old, 5 years old)? ___ Where? _____

Elementary School? _____ Name of School _____ Grade? _____. Has the child ever repeated a grade? _____. If so, what grade? _____. Is the child having problems with school work? _____. If so, what subjects? _____

Has the child received special help at school? _____. List any psychological testing or educational assessment you believe relevant to this evaluation: _____

CURRENT BEHAVIOR: (Please check if the answer is YES)

Bedwetter	___	nightmares	___	temper tantrums	___	thumbsucker	___
extreme fears	___	awkwardness	___	nailbiter	___	overactive	___
frequent cold	___	nervousness	___	shyness	___	Discipline problems	___
staring periods	___	eating problems	___	sleeping problems	___		

Comments _____

Please include any additional information you feel might be helpful. _____

Signature of parents/guardian:

Mother

Father

Guardian