WORD OF MOUTH
Clinical Associates

PARENTS CONFIDENTIAL REPORT

All the following information is for the confidential use of professional staff only. Date: _____

According to our records, you have requested an evaluation for your child. In preparation for this evaluation please provide the requested information on this form.

Please answer the questions as fully and accurately as possible. Many parents have found the child's baby book helpful in remembering particular dates. If you are not sure of a particular date, please write the date that you think is right and put a question mark after it. PLEASE PRINT YOUR RESPONSES.

Child's name: _____ Birthdate: _____ Gender:_____
(first) (last)

Street Address: _____Telephone:_____

City: _____ State:_____ County_____ Zip_____

Child's Physician_____ Referred by:_____

FAMILY INFORMATION

Marital Status of Parents: Married _____ Separated_____ Divorced _____ Widowed _____ Single_____

PARENT #1 NAME:_____(Natural/Adoptive) Birthdate:_____

Age: _____Occupation and place of employment: _____

PARENT #2 NAME:_____(Natural/Adoptive) Birthdate:_____

Age: _____Occupation and place of employment: _____

Describe in your own words your concerns regarding your child:

_____

_____

_____

_____

_____

When did you first become concerned?_____

CHILDREN (use additional page if necessary)

Name	Gender	Birthdate	Age	Neurotypical or Neurodiverse
_____	_____	_____	____	_____
_____	_____	_____	____	_____
_____	_____	_____	____	_____
_____	_____	_____	____	_____

BIRTH HISTORY

Normal Pregnancy?_____ Complications during pregnancy and/or delivery?_____

Any special tests during pregnancy? _____ Diet or medications?_____

Pre-mature/ NICU stay?_____ How long was labor?_____ Number of weeks of gestation:_____

Weight gained: _____ Birth weight: _____

Did baby have any special problems or birth defects?_____

If your child is adopted, please give any information you may have pertaining to biological parents:

_____

_____

Date of adoption (if applicable): _____ Place of birth if your child is adopted:_____

DEVELOPMENTAL HISTORY (Give the age when your child:)

Sat alone: _____Walked alone:_____ Crawled on hands and knees: _____

Said first word: _____ Said first sentences:_____ Fed self:_____

Toilet trained for day:_____ Night: _____ Tied shoes:_____

SCHOOL HISTORY (preschool, day care, etc.)

Name of present school: _____Grade: _____

Teacher: _____ School performance: Superior____ Average____ Poor____

Repeated grades? If yes, which _____ Does your child have poor handwriting? _____

Does your child have difficulty keeping up with notes/note taking in school? _____

Does your child have good or poor attention overall? _____

Difficult subject(s)? _____ Strengths and/or best subjects? _____

Has your child ever had an IEP? _____ Where? _____ When? _____

BEHAVIORAL CHARACTERISTICS

Please circle all traits which best characterize your child's current behavioral characteristics:

cooperative	poor eye contact	attentive	easily distracted
withdrawn	separation difficulties	destructive/aggressive	inappropriate behavior
easily frustrated/impulsive	hyperactive	plays alone for reasonable length of time	

MEDICAL HISTORY

Has your child experienced any of the following? (Please circle all that apply and list child's age at time)

adenoidectomy	encephalitis	seizures	allergies
flu	sinusitis	chicken pox	head injury
sleeping difficulties	frequent colds	measles	meningitis
tonsillectomy	mumps	scarlet fever	vision problems
earaches or draining in ears	hearing problems	vomiting	headaches
serious high fevers	diminished sleep		

Has your child had convulsions, spasms or seizures?_____ How many?_____ When was the last?_____

Does your child wear glasses?_____ Date of last eye exam? _____

Has your child received medical attention for hearing problems? _____ When? _____

Describe:_____

Doctor's name and address:_____

Has your child had an EEG (brain wave test)? _____ When?_____ Where?_____

Why?_____Results:_____

What other serious illnesses, injuries, or surgeries has your child had? _____

_____

Please list any medications that your child takes regularly: _____

_____

Please list any past medications and reason discontinued: _____

_____ _____

Does your child use right or left hand or both?_____

Is your child in good health at this time?_____ Does your child have any physical limitations?_____

Is there a family history of any learning disorders or ADHD? _____

How is the health of other family members?_____

SOCIAL HISTORY:

Describe your child's interests: (play activities)_____

Playmates :(age and gender)_____

What things does your child fear?_____

Is your child nervous?_____ How long does he/she show it?_____

Has your child been harder to manage or discipline than other children?_____

Constantly into everything?_____ Eating problems?_____ Toileting problems?_____

Does your child separate easily from parents?_____

SPEECH AND HEARING:

At what age did your child first say words?_____ What were they?_____

_____

At what age did your child have a name for most common objects and familiar people?_____

At what age did your child combine words into small sentences like: "Want drink" or "Me out"?_____

At what age did your child use more complete short sentences?_____

Did speech learning ever seem to stop for a period of time?_____

Does your child seem to be aware of their speech differences?_____

Do you consider your child to understand directions and situations as well as other children their age? _____

Does your child appear to respond to:

-Their name_____ Soft noises_____ Loud noises_____ Verbal instructions_____

-Verbal instructions with gestures_____ Gestures alone_____

How does your child make his needs known to you?_____

Is there a language other than English spoken in the home?_____ If yes, which language?_____

Does the child understand the language? _____ Which language does the child prefer to speak? _____

Has your child ever: Had a speech/language evaluation/screening? ____ Had speech/language therapy? ___

If yes, where and when? _____

What was your child working on? _____

ADDITIONAL THERAPY OR SERVICES

Has your child received services by any of the following providers: If yes, please give name, address and date seen. Also, please contact those people/agencies below and have them send a copy of their findings to: Word of Mouth Clinical Associates, 5409 Maryland Way – STE 214 BRENTWOOD, TN 37027

Psychologist: _____

Psychiatrist: _____

Pediatrician/Family Doctor:_____

Otolaryngologist:_____

Neurologist:_____

Other doctors:_____

Speech Pathologist:_____

Audiologist: _____

Speech and Hearing Center:_____

Physical Therapy: _____

Occupational Therapy: _____

Social Agency or Worker:_____

State or County Welfare Dept._____

Any testing by local school system:_____

Guidance or Mental Health Center:_____

County Health Dept.:_____

Other agencies:_____

Have you thought about or made application for other services at other agencies for your child?_____

When?_____Where?_____

ADDITIONAL COMMENTS AND OTHER IMPORTANT INFORMATION:

Do you have any other comments to make that you believe would be helpful to us?_____

_____

Do you have any particular questions you would like to ask?_____

_____

Name of person who completed this form and relationship to child:_____

_____

*Portions of the information given on this patient case history may be included in the Background Information section of your child's report. Please list below any information that you would prefer not be included in the report.

_____

_____

_____

Signature: _____

(Parent #1) (Parent #2) (Guardian)