HASA
CIRS Interpreting @ Gateway School
Hearing and Speech-Language Services

PERSON COMPLETING FORM: _____
RELATIONSHIP TO CHILD: _____ DATE: _____

GENERAL INFORMATION

Child's Name: _____ Birth Date: _____

Address: _____

Female ___ Male ___ Social Security # _____ Race _____

Insurance Carrier _____ Policy Holder _____

Insurance Member ID # _____ Group # _____ Policy Holder D.O.B. _____

MA # _____ Managed Care Organization _____

Claims Address _____

Child Referred By _____

Parent 1/ Legal Guardian's Name _____ Email _____

Address _____ Employer _____

Work Phone _____ Home Phone _____ Cell Phone _____

Parent 2/ Legal Guardian's Name _____ Email _____

Address _____ Employer _____

Work Phone _____ Home Phone _____ Cell Phone _____

Is there court ordered custody? Yes__ No__ If yes, who has guardianship? Name _____

Full ___ Partial ___ Temporary ___ Phone _____ Email _____

Social Worker Name _____ Phone _____ Email _____

Attorney Name _____ Phone _____ Email_____

Is there more than one language spoken at home? If so, what is the primary language and what is/are the secondary languages? Yes___ No___ If yes _____

What about your child brings you the most joy?

_____

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DEVELOPMENTAL MILESTONES – Has Your Child Reached the Following Milestones?

	YES	AT WHAT AGE?		YES	AT WHAT AGE?
Imitated/Repeated sounds?			Crawled?		
Said First word?			Stood Alone?		
Regularly used single words?			Walked Alone?		
Used two-word phrases?			Toilet trained?		
Used Sentences?			Fed self?		
Sat alone?			Dressed Self?		

Education

School/Daycare _____ Grade_____

Address _____

Teacher(s) Name(s) _____

School Phone _____ Teacher Email _____

My Child receives: Special Education __ Speech- Language Therapy __ Occupational Therapy __

Physical Therapy ___ Tutoring ___ Other _____

What is your child's attitude towards school? _____

What are your child's areas of greatest interest in school? _____

Have teachers reported concerns about your child's academic performance?

_____

Dates of Most Recent Evaluations and Assessments	**Date Completed**	**Performed By**	**Contact Info (phone/email)**	**Outcome**
Speech-Language Evaluation				
Educational assessment				
Audiological (hearing) screening and/or testing				
Psychological/ Cognitive Evaluation				
Occupational/Physical Therapy evaluation				

Medical – check all diagnoses that apply

__ ADHD	__Bleeding Problems	__Hearing Loss
__Allergies	__Lead Poisoning	__Hospitalized /Surgeries
__Anxiety Disorder	__Diabetes	__Intellectual Disability / Development Disorder
__Apraxia	__Down Syndrome	__Metabolic Problems
__Asthma	__Epilepsy /Seizures	__Seizures
__Autism	__Fragile X Syndrome	__Vision Loss
__Behavior Difficulties	__Head Injury	__Birth Defects

Is there anything else you want to tell us about your child's medical history?

Pediatrician/Physician_____ Date of Last Evaluation_____

Address_____ Phone_____

Medications_____

_____

_____

Pregnancy and Birth History

Did the pregnancy go to full term? Yes__ No__ If no, how many weeks early? _____

Were there any complications /maternal health problems with this pregnancy? (infection, drug exposure, hospitalization, toxemia)

_____

Check type of delivery: head first__ feet first__ breech__ cesarean__

If C-section, please explain_____

Baby's birth weight_____ General Health of baby at Birth_____ NICU stay? Yes__ No__

If yes, please explain _____

Age of baby when discharged home following birth _____

Was your child breast fed _____ or bottle fed _____? Until what age? _____

Were there any problems with breast or bottle feeding? If so, specify_____

Hearing Health History

Has your child had ear infections? Yes__ No__ If yes, how many? _____

Do you think your child has a problem hearing? Yes__ No__ If yes, why? _____

_____

OCCUPATIONAL THERAPY -Check all that apply

__My child has poor posture (potbelly, round shoulders, forward spine curve, and/or works w/ head on desk)
__My child tires easily
__My child has problems with skipping, jumping, hopping, running, & walking as compared to others
__My child has difficulty using scissors, pencils, crayons, or fastening clothes
__My child has difficulty with puzzles
__My child dislikes being hugged
__My child loves the swings at the playground
__My child craves hugs
__My child avoids the swings at the playground
__ My child avoids messy activities
__My child has frequent mood changes
__My child does not seem to know when his/her face is dirty
__My child only eats certain types of foods
__My child omits words and phrases, skips lines, and loses place while reading or copying
__My child is easily distracted
__My child wiggles a lot/ cant sit still
__My child can't tolerate change in routine
__My child uses a pacifier past an expected age
__ My child puts non-food items in the mouth
__My child disorganized/ messy
__My child reverses letters, numbers, words or phrases when writing
__My child has poor spacing of work on paper

__My child's behavior annoys or bothers others
__My child stuffs food into his/her mouth

__My child has difficulty with toileting skills
__My child won't eat
__My child has a family member who has had Occupational Therapy

ADDITIONAL INFORMATION

Thank you for sharing this important information with us. Please include:

- All assessments/ evaluations/ test reports that may be relevant (if applicable)
- Current IFSP or IEP (if applicable)
- a recent photo of your child
- a document with anything else you want to share with us about your child
- For Educational Programs (Gateway School, Child care), please include a $35 application fee.

Staff Use Only:

Forwarded to __Gateway School
__Clinical Services