# WORLD OF WORDS SPEECH AND FEEDING SERVICES, LLC

**5606 N Navarro St., 200 K, Victoria TX 77904 * Phone: 361-220-6455 * Fax: 361-433-0138**

**Personal Information Sheet**

Date: _____ Person Completing Form: _____

Child's Name: _____

DOB: _____ Age: _____ Gender: ____☐____ Male ____☐____ Female

Address:_____

Primary Phone: _____ circle one ☐Home ☐Cell ☐Work ☐Other: _____

**Best Way to contact you in case of an emergency**: Cell phone Work phone Text Email: _____

Do you wish to receive reminders about therapy appoints: ☐Yes ☐No?

If yes email: _____ (email address)

**Contact in Case of Emergency: Provide 2 names**

Name: _____ Phone Number: _____ Relationship to Child: _____

Name: _____ Phone Number: _____ Relationship to Child: _____

List all persons who can bring child to therapy and participate in therapy discussions on therapy day should the need arise
**(ANY CHANGES TO THE LIST MUST BE MADE IN PERSON AND INITIALED AND DATED)**

_____
_____
_____
_____

Parent #1 Name: _____ Parent # 2 Name: _____

Address: _____ Address: _____

City/State/Zip Code: _____ City/State/Zip Code: _____

Parent # 1 DOB: _____ Parent # 2 DOB: _____

Parent # 1 Home Phone: _____ Parent # 2 Home Phone: _____

Parent # 1 Cell: _____ Parent # 2 Cell: _____

Parent # 1 Work #: _____ Parent # 2 Work #: _____

Parent # 1 Email: _____ Parent # 2 Email: _____

Parent # 1 Employer: _____ Parent # 2 Employer: _____

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Child's Name_____ DOB_____

**Insurance Information/Payment Method**

_☐_ **Self-Pay** _☐_ **Primary Insurance:**

Name of Person Insured: _____ Relationship to Child: _____

Insured DOB: _____

Name of Insurance Co./Medicaid: _____Phone Number: _____

ID #/ Medicaid #: _____ Group Number: _____

**Secondary Insurance:**

Name of Person Insured: _____ Relationship to Child: _____

Name of Insurance Co/Medicaid: _____ID#/Medicaid # _____

**Best Treatment Times**

We strive to accommodate your personal schedules to the best of our abilities. Please note below the best times for your child to attend therapy should they qualify. No guarantees will be made about accommodating your schedule but every attempt will be made to do so.

BEST TIMES TO RECEIVE THERAPY

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| 9:00 am<br><br>9:30 am | | | | | |
| 10:00 am<br><br>10:30 am | | | | | |
| 11:00 am<br><br>11:30 am | | | | | |
| 1:00 pm<br><br>1:30 pm | | | | | |
| 2:00 pm<br><br>2:30 pm | | | | | |
| 3:00 pm<br><br>3:30 pm | | | | | |
| 4:00 pm<br><br>4:30 pm | | | | | |

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Child's Name_____ DOB_____

## I. Identifying Information

**Language at Home: _____Other Language: _____**

**Referring Physician: _____ Primary Physician: _____**

**Who does the child reside with (siblings, parents, grandparents, etc.)?**

_____

## II. Statement of Problem

**What concerns do you have in regard to your child's speech/language, physical, feeding, or developmental abilities?**

_____

_____

_____

**When was/were the problem(s) first noted? Any changes since?**

_____

_____

_____

**Family history of speech/language/hearing, physical, feeding, or developmental problems? Yes: ☐ No: ☐**

**Comments:**

_____

_____

**Has your child received:**

**Speech Therapy: ☐ No ☐ Yes When: _____ Where: _____ How long: _____**

**Physical Therapy: ☐ No ☐ Yes When: _____ Where: _____ How long: _____**

**Occupational Therapy: ☐ No ☐ Yes When: _____ Where: _____ How long: _____**

## III. Educational Information/Behavior

**If school age, what school/grade is your child in?**

_____

**Special Educational Services (self-contained, resource, speech, etc.) receiving in school?**

_____

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**How is your child doing academically in school (reading, writing, etc.)?**

_____

_____

**Describe child's interactions with other children/adults?**

_____

_____

## IV. Prenatal/Birth History

**Length of Pregnancy: _____ Length of labor: _____ Was child in NICU? ☐ No ☐ Yes _____ how long**

**Length of hospital stay/complications:**

_____

_____

**Birth Weight: _____Oxygen Required: ☐No ☐Yes Comments: _____**

**Type of Delivery: ☐ Natural ☐ C-section Comments: _____**

**Labor Induced: ☐ No ☐ Yes Comments: _____**

**Breech: ☐ No ☐ Yes Comments: _____**

**Mother's general health during pregnancy (complications, accidents, illnesses meds)**

_____

_____

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## V. Medical History

**List any diagnoses that have been given to your child and by whom: ☐ My child has no formal diagnosis.**

| Diagnosis | Who Gave |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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**Has your child had any surgeries or accidents? ☐ No ☐ Yes (Please list when and what)**

_____

_____

**Please list all medications your child is currently taking including over the counter medications: _____ No Medications**

| Drug Name | Dosage | Frequency |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Please List all doctors your child is currently seeing:**

| Physician's Name | Phone Number | City |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Allergies: Please check all allergies that your child has**

- **Food** _____
- **Non-food** _____
- **Latex** _____
- **Medications** _____

**Has your child had ear infections? ☐ No ☐ Yes If yes, how many in the last year? _____**

**Does your child have PE tubes? ☐ No ☐ Yes If yes, when: _____**

**Has your child's hearing been checked? ☐ No ☐ Yes If yes, when _____**

**Where: _____ Results: _____**

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Child's Name_____ DOB_____

**Does your child have any vision problems ☐ No ☐ Yes If yes, describe? _____**

_____

**Has your child seen an ophthalmologist? ☐ No ☐ Yes If yes, When: _____**

**Where: _____ Results: _____**

**Are there any medical precautions the therapist should be aware of when working with your child?**

_____

_____

**Does your child currently have any assistive devices (eg: glasses, casts, wheel chair, speech generating device)?**

_____

_____

**What concerns you the most about your child?**

**Are there problems with any daily routines?**

**Please tell us about your child's strengths and gifts.**

**What particular skills would you like your child to achieve in the next six months?**

**How, if in any way, would you like to interact differently with your child?**

**Favorite toys/food?**