

## PRESCHOOL/EARLY CHILDHOOD PARENT INFORMATION FOR REFERRAL TO ESU 8 FOR PSYCHOLOGICAL AND/OR SPEECH-LANGUAGE SERVICES

Your child has been referred for psychological and/or speech-language evaluation. Information from parents is very important in gaining a full understanding of your child. Please answer all questions completely. Please use more paper if you need to.

### I. Family Information

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender Assigned at Birth: M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary language at home: \_\_\_\_\_ Interpreter needed: Yes  No

Mother's name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Best time to reach you: \_\_\_\_\_ Do you prefer: Call  Text  Email

Student lives with:

Have any family members had learning/health/mental health needs? If so, please explain:

### II. Developmental History

Describe any complications during pregnancy (e.g. early labor, blood pressure, prescribed bed rest, fluid retention) or delivery (e.g. premature birth, oxygen deprivation):

Have you or your medical provider had concerns with your child's developmental milestones (i.e. sitting, walking, talking, toilet training). If so, please describe:

### III. Medical History

Has your child ever received care for medical, emotional, behavioral, or genetic reasons such as:

- |  |  |
|--|--|
| <input type="checkbox"/> Birth-related difficulties      | <input type="checkbox"/> Staph infection               |
| <input type="checkbox"/> Genetic disorder                | <input type="checkbox"/> Hard fall or blow to the head |
| <input type="checkbox"/> Seizure disorder                | <input type="checkbox"/> Concussion                    |
| <input type="checkbox"/> Speech/ hearing difficulties    | <input type="checkbox"/> Blurred vision                |
| <input type="checkbox"/> Attention Deficit/Hyperactivity | <input type="checkbox"/> Loss of consciousness         |
| <input type="checkbox"/> Childhood depression            | <input type="checkbox"/> Motor Issues                  |
| <input type="checkbox"/> Anxiety                         | <input type="checkbox"/> Medical Hospitalizations      |
| <input type="checkbox"/> High fever                      | <input type="checkbox"/> Other _____                   |
| <input type="checkbox"/> Allergies                       |  |
| <input type="checkbox"/> Recurrent ear infections        |  |

If you checked yes to any of the above, please describe if your child is still receiving care for it:

Has your child had hearing tested? Yes  No  If yes, what were the results:

Has your child had vision tested? Yes  No  If yes, what were the results:

If your child takes prescribed medication or herbal remedies, please give the name, the dosage, and what it is for:

\_\_\_\_\_

Please describe any known disabilities: \_\_\_\_\_

When and how did you first become aware of the condition(s)? \_\_\_\_\_

Please include a copy of any previous evaluations not done by ESU 8 that relate to your concern.

#### IV. Language and Communication

Please check the things below that describe your child:

- Difficult to understand (i.e. leaves out sounds)
  - Substitutes sounds
  - Difficulty imitating sounds or words
  - Doesn't follow simple one-step directions (i.e. "Go get your ball")
  - Doesn't follow two-step directions (i.e. "Go get your ball and put it in the toy box")
  - Limited vocabulary-difficulty labeling familiar objects or people
  - Not able to point to or identify pictures in books
  - Doesn't answer simple questions (who, what, where, when)
  - Doesn't ask questions
  - Doesn't use "-ing" on verbs
  - Doesn't use "-ed" on verbs
  - Doesn't use negatives (i.e. don't, can't, won't)
- Doesn't use:    3-5 word phrases    4-6 word phrases    5-8 word phrases

Describe any speech-language problem(s) in more detail. How often does the problem occur? Where does it occur?

#### V. Your Child

What concerns do you have for your child?

What are you doing at home to help with these concerns? Is it working? Please be specific. (discipline used, rewards, spending individual time with child, etc.)

Describe your child's strengths (i.e. what does she/he do well?):

Describe your child's weaknesses (i.e. what is difficult?):

What are your child's favorite activities?

Describe how your child plays with other children:

Describe how your child interacts with adults:

What responsibilities does your child have at home?

Describe your child's behavior at home. How does this compare to his/her behavior when you are in public?

Describe your child's response to new situations:

Are there concerns that you would like to discuss in person (i.e. with the psychologist, speech pathologist, early childhood educator, mental health professional)? Yes  No

If yes, with whom? \_\_\_\_\_