

Medicaid# _____

Robert L. Milisen Speech-Language Clinic
Indiana University
200 S. Jordan Avenue
Bloomington, IN 47405
(812) 855-6251

Preschool Application Form

I. Identifying Information

Today's Date _____

Child's Name _____ Age _____ Birth date _____
Sex of Child _____

Child's Home Address _____

Names of parents/guardians _____

Mother

Father

Address _____

Address _____

Occupation _____

Occupation _____

Phone: Home () _____

Phone: Home () _____

Work () _____

Work () _____

Are languages other than English (including sign language) used at home? ___Yes ___No If so, what language(s)?

II. Referral

How did you hear about our program? _____

Do you have concerns about your child's speech and language development? ___yes ___no

If yes, explain here: _____

Is/Has your child received speech/language and/or developmental services? ___yes ___no

If yes, please note type of therapy, the therapist and contact information here: _____

What do you hope your child to gain from the program? ___language stimulation ___learning more English
___getting a head start ___a general preschool experience ___to correct speech & language problems
other: _____

III. Communication Skills

What does your child use the most? complete sentences phrases one or two words sounds gestures
 physically takes adult to item augmentative communication system (pictures, etc.)

At what age did your child say his/her first word? _____

What were the child's first few words? _____

Approx. how many words did the child have at...

18 months? _____

24 months? _____

At what age did the child say his/her first sentence? _____

Give some example of first sentences:

Give an example of typical sentences the child currently uses:

Estimate the percent of time that your child is understood by: parents other adults brothers and sisters friends

Please indicate your child's level of understanding of other's by checking those that apply:

understands gestures does not understand spoken words understands single words understands simple sentences

understands 2 and 3 part commands understands conversation

IV. Hearing

Yes No

Do you feel your child hears well?

Has your child ever had an ear infection? If so, which ear _____

Last occurrence _____ First occurrence _____ Frequency _____

Does he/she presently have or in the past had draining ears?

Does he/she wear hearing aids?

If yes: Make and model _____ since _____

Has your child ever had a hearing test? When? _____

What were the results? _____

V. Prenatal (pregnancy), Birth and Development

Mother's date of birth _____ Father's date of birth _____

Length of pregnancy in weeks _____

Explain any complications during pregnancy _____

Did you have a normal delivery with this child? yes no

If no, please explain _____

Were there any problems or complications immediately following birth or during the first two weeks of your infant's life? (feeding, seizures, sleeping, swallowing, hospitalizations, etc.) _____

In your opinion, is your child **typical** for his/her age in:

self-help skills

social skills

eating yes___ no___
toileting yes___ no___
dressing yes___ no___

playing with peers yes___ no___
general social interactions yes___ no___

Please explain any areas checked as "no": _____

In your opinion, is your child **typical** for his/her age in:

large muscle skills

small muscle skills

walking yes___ no___

coloring yes___ no___

running yes___ no___

cutting yes___ no___

jumping yes___ no___

building with blocks yes___ no___

going up stairs yes___ no___

throwing/catching a ball yes___ no___

Please explain any areas checked as "no": _____

Would you describe your child's coordination as: ___good ___fair ___poor

VI. Medical History

Name of child's Pediatrician/Doctor _____

Address _____

Telephone _____

City _____

State _____

List any past or current health problems your child has:

Does your child have allergies (including **food**) ? ___yes ___no If yes, please elaborate:

Is your child currently on medication? ___yes ___no If yes, please explain: _____

Do you have any concerns about your child's eyesight? ___yes ___no If yes, please explain: _____

Other: _____

VII. Cognitive History

Has your child ever had a neurological or multidisciplinary team evaluation? ___yes ___no

Any other relevant evaluations? ___yes ___no

Please provide us with a copy of any evaluation reports you may have.

VIII. Day care and school experiences

Does your child attend: ___daycare ___preschool ___other _____

Name of daycare or school _____

Address _____ Phone _____

City _____ County _____ State _____ Zip _____

When is he/she in the daycare or preschool program? _____

Other programs your child has attended: _____

IX. Home and family

Please list individuals who live in the home of the child:

| Name | Date of birth | Age | Sex | Relationship |
|-------|---------------|-------|-------|--------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Do any of the above individuals have speech, language or hearing problems? yes no If yes, please explain: _____

Are there any other family members (grandparents, cousins, etc) that have a hearing loss or communication problem? yes no If yes, please explain _____

X. Miscellaneous

Nickname _____

Favorite activities _____

Special food likes or dislikes (indicate which category) _____

Any other information that you think would be helpful for us to know about your child: _____
