

**WESTERN SCHOOL CORPORATION  
SPEECH AND HEARING THERAPY  
ROUND-UP**

CHILD'S Name \_\_\_\_\_ Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Please answer the following questions to the best of your ability.

1. Has your child ever suffered an ear injury? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_

\_\_\_\_\_

2. Is your child under doctor's care for any illness? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_

\_\_\_\_\_

3. Are you aware of any hearing problems that your child may have at the present time?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_

\_\_\_\_\_

4. Has your child ever received speech and/or language help in the past:  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please tell where received: \_\_\_\_\_

5. Other comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent Signature \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Screening Results: [office only]

**Speech**

**Hearing**

P	F	R	O

P	F	R	O

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_