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2026 PATIENT RE-EVALUATION FORM

Patient Personal Information

Last Name: _____ First Name: _____ Date of Birth: _____
Street Address: _____
City/State/ZIP: _____
Child lives with: [ ] Parent(s) [ ] Guardian(s) [ ] Other _____
Other children in the family (if more lines are needed, please add to the back of this form):

Name:	Age:	Sex:	Relationship to patient:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How has your child's speech & language changed in the past 6 months?
_____
How has your child's fine motor/sensory processing changed in the past 6 months?
_____
How have your child's habits/schedule changed in the past 6 months (meals, naps, school, bedtimes)?
_____
_____

Academic Information

School: _____ Grade/ Program: _____
Current IEP: Y N (circle one)
If yes, what services?:_____
Any academic concerns?_____

Medical Information

Child's Physician Office: _____ Pediatrician: _____
Does your child take any medications? : Y N (circle one)
If yes, please list: _____
Does your child receive other therapies? : Y N (circle one)
If yes, what therapies and how often: _____
Does your child have any known allergies? : Y N (circle one)
If yes, what are they?: _____
Has your child had any recent surgeries?: _____
Does your child have any new diagnosis (by psych or neuro)? : Y N (circle one)
If yes, what is it? _____
Any new concerns or additional pertinent information:
_____
_____

_____ _____
Parent/Caregiver Name Date

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