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Client History Form

Confidential and Privileged Information

GENERAL INFORMATION

Today's date ____________

Name ____________________

Address ____________________ **City** ____________ **Zip** ________

Date of Birth ____________ Age ____________ Gender ☐ Male ☐ Female **Twin** ☐ Yes ☐ No

Person(s) with whom the client lives ____________________

Who has legal custody of the child? ____________________

Physician's Name ____________________ Telephone ____________

Address ____________________ City ____________ Zip ________

Dentist's Name ____________________ Telephone ____________

Address ____________________ City ____________ Zip ________

Daycare ____________________ Telephone ____________

Teacher ____________________ Address ____________

City ____________________ Zip ________

Preschool ____________________ Telephone ____________

Teacher ____________________ Address ____________

City ____________________ Zip ________

School ____________________ Telephone ____________

Grade ________ Teacher ____________________

Address ____________________ City ____________ Zip ________

Father's Name ____________________ Years of Education ________

Occupation ____________________ Employer ____________

Home phone ____________ Work phone ____________ Cell phone ____________

Father's email address ____________________

Mother's Name ____________________ Years of Education ________

Occupation ____________________ Employer ____________

Home phone ____________ Work phone ____________ Cell phone ____________

Mother's email address ____________________

Stepparent's Name____Years of Education ________

Occupation____Employer ______________________

Home phone_______________________Work phone____________________Cell phone __________

Stepparent's email address ____

Other children in the family:

Name____Age ____________

Name____Age ____________

Name____Age ____________

Name____Age ____________

Primary language ____

Language spoken at home ____

Do any other family members have a speech, language or hearing problem? ☐No ☐Yes

If yes, please state the family member's relationship to the child and describe the speech, language or hearing problem:

____

____

____

____

Please fill in the information for any of the evaluations your child has had.

	Provider	When	Findings/Recommendations
Speech language evaluation			
Occupational therapy evaluation			
Physical therapy evaluation			
Neurological testing			
Allergy testing			

Reason for referral to this office? _

Whom may we thank for referring you? ____

PRENATAL AND BIRTH HISTORY

This child is your: ☐ biological child ☐ adopted child ☐ foster child

Mother's age at child's birth ______

Did mother receive routine prenatal care? ☐ Yes ☐ No

Describe mother's pregnancy. Include any unusual illnesses, accidents or conditions that occurred such as German measles, false labor, Rh incompatibility, etc.

___

___

___

Length of pregnancy________ Duration of labor__________ Child's birth weight ________

Conditions at birth

Cesarean ☐ Yes ☐ No Breech ☐ Yes ☐ No Anesthetics ☐ Yes ☐

Forceps ☐ Yes ☐ No Jaundiced ☐ Yes ☐ No Was the infant blue? ☐ Yes ☐ No

Describe other unusual conditions at birth:

___

___

___

MEDICAL

Describe your child's current health status ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your child currently taking any medications? ☐ No ☐ Yes – list below:

Medication Name	Dosage	Length of time on medication	Uses

Please indicate at what age(s) your child experienced any of the following:

Earaches______________________ Tonsillectomy________________________ Adenoidectomy _________________

Head injury_____________________ Vision problems______________________ Convulsions ___________________

Frequent colds__________________ Frequent congestion___________________ Allergies or Asthma ______________

Surgery/Hospitalization - indicate procedure and/or cause as well as age:

___

___

___

List any other significant childhood diseases or accidents, along with the child's age at the time:

____

____

____

Other health problems:

____

____

____

Please list any food allergies:

____

____

____

If your child has seen a physician other than a primary care physician, please provide:

Physician's Name____Telephone ______________

Specialty (such as ENT)____Address ________

City____Zip ___________

SOCIAL

Describe any factors in the home that may relate to your child's current communication challenges.

____

____

____

Describe any unusual behaviors such as head banging, rocking, excessive need for routine, significant difficulty with transitions, inability to tolerate unexpected changes in daily routine

____

____

____

Does your child make friends easily? ☐ Yes ☐ No

Check the box for each line that best describes your child's personality:

☐ Shy	☐ Outgoing
☐ A leader	☐ A follower
☐ Quiet and reserved	☐ Outgoing and talkative

What are your child's favorite books?

____

____

What are your child's favorite toys and activities?

____

____

Describe communication challenges your child has with

Father ____

Mother ____

Siblings ____

Teachers ____

Peers ____

Others ____

Is your child aware of his challenges? ☐ Yes ☐ No

If yes, what is your child's reaction to his communication challenges? Does he sometimes get frustrated (or stop talking) when he cannot make himself understood? How frequently does this frustration occur each day?

____

____

____

How much time does your child spend watching TV each day? ___________________________

How much time does your child spend playing iPad or computer games? __________________

Please list other activities in which your child currently participates:

____

____

SPEECH, LANGAUGE AND HEARING DEVELOPMENT

At what age did your child:

Sit alone_______Walk alone_________Say first words Combine words _______

Does your child prefer right or left hand? ☐ Right ☐ Left

Does your child appear awkward or uncoordinated? ☐ Yes ☐ No

Does your child have difficulty chewing or swallowing? ☐ Yes ☐ No

At what age was your child toilet trained? _______

Thumb or finger(s) sucking habit?

☐ Yes, current habit

☐ Not anymore

Age at which the child discontinued the habit _______

Pacifier habit?

☐ Yes, current habit

☐ Not anymore

Age at which the child discontinued the habit _______

Does your child have a hearing loss currently? ☐ Yes ☐ No

Has your child ever had hearing difficulty? ☐ Yes ☐ No

Does your child have frequent ear infections? ☐ Yes ☐ No

Did your child have frequent ear infections in the past? ☐ Yes ☐ No

Does your child have tubes? ☐ Yes ☐ No

If yes, please list the child's age(s) when the tubes were inserted ______________________________

Who first noticed your child's speech/language delay? _

When did this happen?____

During the first year, did your baby

Coo ☐ Yes ☐ No

Babble jargon ☐ Yes ☐ No

During the first year, which of the following best describes your baby (at times other than when crying)

☐ a silent baby

☐ a very quiet baby

☐ an average noisy baby

☐ a very noisy baby

Write the age at which your child:

said first words

named people and objects _________

combined words (i.e., "Mama up")_________

used complete short sentences (i.e., "I ride bike.") _________

What percent of your child's speech do you understand? _________ Your spouse? _________

What percent of your child's speech do those outside the family say they understand?

Has your child's preschool or school teacher commented on his speech intelligibility? _________

Does your child seem to understand what you say to her? ☐ Yes ☐ No If no, please explain: ____________________

____

Does your child require frequent repetitions of directions before complying? ☐ Yes ☐ No

Did your child's speech development seem to get stalled for a period of time? ☐ Yes ☐ No

If yes, at what age? _________

Does your child:

Follow directions ☐ Yes ☐ No

Ask questions ☐ Yes ☐ No

Mispronounce sounds ☐ Yes ☐ No

Have difficulty with pronouns and correct verb tenses ☐ Yes ☐ No

Repeat whole words (i.e., "I I I am hungry.") ☐ Yes ☐ No

Repeat parts of words (i.e., "Ca ca ca can I play now?") ☐ Yes ☐ No

Say "Huh?" excessively ☐ Yes ☐ No

Use signs to communicate ☐ Yes ☐ No

If yes, approximately how many signs does your child use regularly?_________

Has there been change in your child's speech in the last six months? ☐ Yes ☐ No

If yes, please describe ______________________________

____

Has there been change in your child's speech within the last year? ☐ Yes ☐ No

If yes, please describe ______________________________

____

SCHOOL

At what age did your child begin (if applicable):

________ Daycare	________Preschool
________ Kindergarten	________First Grade
________ Special Education	________Speech Therapy

Is your child currently enrolled in speech therapy? ☐ Yes ☐ No

If yes, is speech therapy provided

☐at school

☐ privately

If your child receives other special school services (i.e., 504 designation, Gifted and Talented) please list them:

____

Has your child repeated a grade? ☐ Yes ☐ No

If yes, what grade(s) ________

Why ______________________________

____

With what subjects does your child have difficulty?

____

Describe the nature of the difficulty.

____

____

Is homework a struggle? ☐ Yes ☐ No

About how much time does your child spend doing homework each night? ________

Does your child enjoy going to school? ☐ Yes ☐ No

BEHAVIORS

During your child’s first one to two years of life, were any of the following of concern to you:

- ☐ Colicky behaviors
- ☐ Poor sleeping habits
- ☐ Not easily calmed or comforted
- ☐ Did not enjoy cuddling
- ☐ Did not seem to “connect” with you
- ☐ Difficulty with nursing or bottle feeding
- ☐ Excessive irritability
- ☐ Poor eye contact
- ☐ Did not respond to name or speech
- ☐ Fascination or obsession with certain objects or activities
- ☐ Excessive interest in lining up objects or toys

If you answered “yes” to any of these behaviors, please describe in more detail:

AND FINALLY...

What do you think is your child's primary difficulty?

What have you been told is the cause of your child's challenges?

Do you have other concerns about your child?

What do you think might help your child?

What things have your tried in an effort to help your child?

What special talents and strengths does your child have?

Please write any questions that you would like to have addressed as a part of this evaluation:

Signature of person completing this form ______________________________

Date ______________ Relationship to client ______________________________