

## Client History Form

CHILD, PARENT & DEMOGRAPHIC INFORMATION	
Child's First & Last Name	
Nickname, if applicable	
Male/Female	
Date of Birth/Age	
Requesting M.D.	
Child's Insurance Coverage	
Primary Parent(s)/Guardian Name	
Home Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
Other Phone & email	
In case of emergency contact (other than primary)	
Relationship	
Emergency contact's phone	
Describe your concerns about your child's communication:	

BIRTH HISTORY	
Where was the child born (hospital/town)?	
How much did he/she weigh?	
Did mother have any illnesses or other problems during her pregnancy with this child?	YES/NO
-If yes, what?	
Take medications (other than vitamins)?	YES/NO
- If yes, what?	
Alcohol, tobacco, drugs?	YES/NO
- If yes to any of these, explain:	
Was the delivery of the child normal	YES/NO
C-section	Breech
Other	_____
Was the child premature?	YES/NO
How long was the pregnancy?	
How old was he/she when adopted?	
Was there an extended stay in the hospital?	YES/NO
Is the child adopted?	YES/NO
Did the child have trouble after birth?	YES/NO

Description of Birth Troubles	Explanation	YES	NO
Was blue/cyanotic at birth			
Required stimulation to breathe			
Required oxygen at birth	How much/what type?		
Required resuscitation			
Was considered small for gestational age			
Had tremoring or seizures	Which/for how long?		
Very low tone			
Brain hemorrhage			
Anemia and/or transfusions	Which/for how long?		
Very low tone			
Brain hemorrhage			
Anemia and/or transfusions	Which/how many times?		
Jaundice (yellow)	How much/how treated?		
Had bruising			
Rh incompatibility problems			
Infections			
Congenital birth defects			
Aspiration (meconium or fluid)	Which/how treated?		
Respiratory distress signs or syndrome			
Needed ventilation	What type/how long?		
Choking or vomiting episodes			
Tube feedings			
Needed medications			
Was there an extended stay in the hospital?		YES/NO	
Is the child adopted?		YES/NO	
How old was he/she when adopted?			

FAMILY			
Are the parents married/divorced?			
If so, how old was the child when this occurred?			
Who has custody of the child?			
Is the current marriage the first marriage for the mother?	YES/NO	For the father?	YES/NO
Is the mother deceased?	YES/NO	Is the father?	YES/NO
Fathers occupation:	Where?		
Fathers level of education:	Age:		
Mothers occupation:	Where?		
Mothers level of education:	Age:		
Stepparents or other significant caregivers:			
Name:	Relationship to child:		
Occupation:	Age:		
Name:	Relationship to child:		
Occupation:	Age:		
Give names and ages of other children in the family:			
If both parents work, who takes care of the child?			
Are other children present?			
Is there any other family members who have had a history of speech/language and/or learning delays?			
How old was the child when the mother went to work?			

Are there persons living in the home other than the parents and children? YES/NO Who?
Is any language other than English spoken in the home? YES/NO What? How often?

EARLY DEVELOPMENT	
1. Was the child very active as a baby?	YES/NO
2. At what age did the child: Sit alone: Crawl: Walk: Was he/she content to stay in his bed? YES/NO Did he/she enjoy being held? _____ Rocked? _____ Cuddled? _____	
3. Was feeding the child a problem? YES/NO If yes, how? Was he/she breast-fed? YES/NO Bottle fed? YES/NO When was he/she weaned from the bottle? Was weaning difficult? YES/NO If yes, why?	
4. Is the child a good eater? YES/NO picky? YES/NO messy? YES/NO Does he/she seem to have any trouble swallowing? YES/NO chewing? YES/NO If yes, describe:  Does he/she have any trouble clearing his/her mouth of food? YES/NO Explain:  Will he/she eat meat and caramels? YES/NO Does the child feed self with a spoon? YES/NO Fork? YES/NO Both? YES/NO	
5. Is the child completely toilet trained? YES/NO At what age?	
6. Does the child dress him/herself completely? YES/NO Partially? YES/NO Does he/she completely undress him/herself? YES/NO Partially? YES/NO Does he/she button? YES/NO Tie shoes? YES/NO Is he/she "particular" about the kind of clothes he/she wears? YES/NO If yes, describe:	
7. Does your child fall frequently? YES/NO Can he/she climb? YES/NO Throw a ball? YES/NO Hit a ball? YES/NO Run? YES/NO Jump/hop? YES/NO Ride a trike? YES/NO Ride a bike without training wheels? YES/NO	
8. Does the child use right or left hand to eat? _____ Draw or write? _____ Throw a ball? _____	

### SPEECH/LANGUAGE HISTORY

1.	Has your child had a speech or language test before? YES/NO	Results:
2.	As an infant, did the child cry excessively? YES/NO	
	Did he/she babble or coo? YES/NO	
	Was he/she quiet most of the time? YES/NO	
3.	How old was he/she when he/she began to say words?	
	What were his/her first real words?	
	Does he/she speak in complete sentences now? YES/NO	
	Can he/she follow simple directions? YES/NO	Complex directions? YES/NO
	Give examples of his words or phrases now	
4.	How much of his/her speech can mother understand? All Most Some None	
5.	How much does the child use gestures to help others understand?	
6.	Has the child learned to say nursery rhymes? YES/NO	Prayers? YES/NO Songs? YES/NO
7.	Does the child stutter or stammer? YES/NO	Describe:
8.	What have you done to help the child with his/her speech?	

### SCHOOL HISTORY

1.	Where does he/she attend daycare? _____	Preschool? _____
2.	Kindergarten? _____	
	What grade is in the child in? _____	What school? _____
	Has he/she repeated in any grades? YES/NO	Which grades? _____
	What grade is he/she making in Reading? _____	Spelling _____ Arithmetic _____ Writing _____
	Conduct _____ Science _____ Social Studies _____	
	Has he/she ever been enrolled in special classes? YES/NO	
	What kind of classes? When? Where?	
3.	Does the child like to go to school? YES/NO	
	Can he/she follow directions in school? YES/NO	
	Does he/she attend school regularly? YES/NO	
	If not, why?	
	How does he/she get along with his/her teachers? How does he/she get along with other children at school?	

**MEDICAL/HEALTH HISTORY**

1. Medical diagnosis or conditions	
2 List all allergies & reactions to each allergy.  (ex. Peanuts/breaks out in hives)	
3 Does your child have emergency medication? If so, list all and be sure to bring during program. (ex: seizure or epinephrine pen)	
<b>HEARING</b>	
1. Does your child have frequent colds or ear infections? YES/NO How often? _____ Has your child had a hearing test? YES/NO Results: _____ Has your child had tubes in their ears? YES/NO When? _____ How many sets? _____	
<b>VISION</b>	
1. Does your child see? YES/NO	
2. Has your child had a vision test? YES/NO Results _____	

**ACTIVITY INFORMATION**

Can your child attend to sit down activities for 30 minutes or more?	
Can your child follow 2 to 3 step directions/commands/requests?	
Does your child respond negatively to certain textures, tastes, sounds, or touch? If so please explain.	
Is your child toilet trained? If no, what are his/her toileting needs?	
Does your child have any behavior issues that we should be aware of? If yes, please explain.	
Does your child require any special equipment? (Wheelchair, Hearing aid, Walker, etc.) If yes please explain what type of equipment is needed?	

**PERSONALITY AND BEHAVIOR**

1. Below is a list of words which describe a child's personality and behavior. Please circle those which you feel describe your child.

- |                       |                      |                      |
|-----------------------|----------------------|----------------------|
| sad                   | quiet                | prefers to be alone  |
| happy                 | very active          | is unusually fearful |
| even tempered         | a follower           | sucks thumb          |
| affectionate          | has trouble sleeping | sucks pacifier       |
| is hard to discipline | distractible         | other: _____         |

2. Describe any behavior which is a problem to parents.

How often does he/she have temper tantrums?

3. Does your child enjoy being read to? YES/NO

Reading to him/herself? YES/NO

Does he/she like to watch TV? YES/NO

For how long? \_\_\_\_\_

What programs? \_\_\_\_\_

4. What are the child's favorite activities?

5. How well does the child play alone?

Does the child play better with older children? Younger children? Or children of same age?

**If there is anything else you feel would help us better prepare for this client's evaluation, please let us know:**

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\_\_\_\_\_  
Client/Parent Signature

\_\_\_\_\_  
Date

**THANK YOU FOR PROVIDING THIS HELPFUL INFORMATION. IT WILL AID IN GIVING US A MORE COMPLETE PICTURE OF YOUR CHILD'S OVERALL SPEECH AND LANGUAGE DEVELOPMENT.**