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Speech-Language Pathologist

NEW CLIENT INFORMATION

(*Please Print Clearly)*

Child's Name: ______________________ Birth Date: _____________ Sex: ☐ M ☐ F

Father's Name: _____________________
Address: __________________________
____
Occupation: _______________________
Daytime Phone: ____________________
Cell Phone: _______________________
E-Mail: ___________________________
Who referred you? _________________

Mother's Name: ____________________
Address: __________________________
____
Occupation: _______________________
Daytime Phone: ____________________
Cell Phone: _______________________
E-Mail: ___________________________

Is there a language other than English spoken in the home? ☐ yes ☐ no
If yes, which one? ____
Does the child speak the language? ☐ yes ☐ no
Does the child understand the language: ☐ yes ☐ no
Who speaks the language? ____
Which language does the child prefer at home?

Other children in the family:

Name	Age	Sex	Grade	Speech/Language Issues

Birth History:

Was there anything unusual about the pregnancy or birth? ☐ yes ☐ no
If yes, please describe. ____
____

How old was the mother when the child was born? ____________________________
Was the mother sick during the pregnancy? ☐ yes ☐ no
If yes, please describe. ____
How many months was the pregnancy? ____________________________________
Did the child go home with his/her mother from the hospital? ☐ yes ☐ no
If the child stayed at the hospital, please describe why and how long. __________
____
____

Does your child have a medical diagnosis? ☐ yes ☐ no
If yes, please provide all diagnoses, when and who made the diagnosis. _______
____
____
____

Medical History:

Has your child had any of the following?

☐ adenoidectomy	☐ encephalitis	☐ seizures
☐ allergies	☐ flu	☐ sinusitis
☐ breathing difficulties	☐ head injury	☐ sleeping difficulties
☐ chicken pox	☐ high fevers	☐ thumb/finger sucking
☐ colds	☐ measles	☐ tonsillectomy
☐ ear infections	☐ meningitis	☐ tonsillitis
How often? ________	☐ mumps	☐ vision problems
☐ ear tubes	☐ scarlet fever	

Other serious injury/illness/surgery/hospitalizations: ____________________________
____

Is your child currently under a physician's care? ☐ yes ☐ no
If yes, why? ____

List any medications your child takes regularly: ________________________________
____

Does your child…

☐ choke on food or liquids?
☐ drool?
☐ currently put toys/objects in his/her mouth?
☐ brush his/her teeth and/or allow brushing?
☐ have a history of feeding difficulties?
If yes, please describe. ____
____

Has your child had a hearing evaluation/screening? ☐ yes ☐ no
If results were abnormal please describe. ______________________________

Has your child has a vision evaluation/screening? ☐ yes ☐ no
If results were abnormal please describe. ______________________________

Primary care physician: ____
Address: ____
Phone: __________________

Developmental History:

Approximate age your child achieved the following developmental milestones:

_______ sat alone	_______ babbled
_______ crawled	_______ said first word
_______ walked	_______ put two words together
_______ toilet trained	_______ spoke in short sentences

School/Program History:

Name of school/daycare: ____

Grade or program (if not general education): ______________________________

Has your child repeated a grade? ____

What are your child's strengths? _______________________________________

____

____

What is your child having difficulty with in school? ___________________________

____

____

Services:

Has your child ever had a speech and language evaluation? ☐ yes ☐ no

If yes, where and when? ____

What were you told? ____

Has your child ever received speech therapy? ☐ yes ☐ no

If yes, where, when and for how long? _____________________________

____

Has your child received any other evaluation or therapy (physical therapy, occupational therapy, behavioral therapy, vision, etc?) ☐ yes ☐ no

If yes, please describe. ____

____

____

____

What services is your child currently receiving, where and for how long?

____

____

____

Is your child aware of, or frustrated by, any speech/language difficulties?____________

____

What do you see as your child's most difficult problem at home? __________________

____

What do you see as your child's most difficult problem at school? _________________

____

Current Speech-Language:
Does your child…

- ☐ repeat sounds, words, or phrases over and over?
- ☐ understand what you are saying?
- ☐ retrieve/point to common objects upon request (e.g., ball, cup, shoe)?
- ☐ point to pictures of familiar items in a book
- ☐ follow simple directions
- ☐ respond correctly to yes/no questions?
- ☐ respond correctly to who/what/where/when/why questions?

Your child communicates using…

- ☐ body language
- ☐ sounds (vowels, grunting)
- ☐ word approximations
- ☐ words
- ☐ 2 to 4 word sentences
- ☐ sentences longer than four words.
- ☐ other ______________________

Behavioral Characteristics:

- ☐ cooperative
- ☐ attentive
- ☐ willing to try new activities
- ☐ plays alone for reasonable length of time
- ☐ separation difficulties
- ☐ easily frustrated/impulsive
- ☐ stubborn
- ☐ restless
- ☐ poor eye contact
- ☐ easily distracted/short attention
- ☐ destructive/aggressive
- ☐ withdrawn
- ☐ inappropriate behavior
- ☐ self-abusive behavior

Please describe your child's social language skills and play with others.

____
____
____

Please describe your goals for your child regarding speech/language/communication.

____
____
____

Additional Comments:

____
____
____