



The Speech Language Learning Center

Client Information Sheet (child)

Date: _____

Client Full Name: _____

Date of Birth: ___/___/___ Age: ___ Sex: ___

Telephone: Home #: _____ Cell#: _____

Home Address: _____

Mother's Name: _____

Father's Name: _____

Sibling's/Ages: _____

Primary Care Physician: _____ Phone #: _____

Others Living in the Home: _____

Languages Spoke in the Home: _____

WHO IS RESPONSIBLE FOR THE CLIENT'S BILLS? _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Social Security #: _____

Date of Birth: ___/___/___

Employer: _____

Phone # of Employer: _____

Address of Employer: _____

WHOM MAY WE CONTACT IN THE EVENT OF AN EMERGENCY (OTHER THAN PARENT)?

Name: _____

Telephone #: _____

Relationship: _____

WHO CAN WE THANK FOR REFERRING YOU:

BIRTH HISTORY

Pregnancy:

Age of Mother: _____ Length of Pregnancy: _____

General Health of Mother: _____

Complications: _____

Medications taken during pregnancy: _____

Delivery:

Duration of Labor: _____ Type of Delivery: _____

Difficulties during delivery: _____

Birth weight: _____ Birth Length: _____

Intensive Care (NICU) needed? Yes No Length of Stay: _____

Any health problems the first 2 weeks of life? _____

MEDICAL HISTORY

Hospitalizations: Yes No Describe: _____

High Fevers: Yes No Describe: _____

Ear Infections: Yes No Describe: _____

Hearing Problems: Yes No Describe: _____

Vision Problems: Yes No Describe: _____

Allergies: Yes No Describe: _____

Surgeries: Yes No Describe: _____

Seizure Disorder: Yes No Describe: _____

Colic: Yes No Describe: _____

Is your child presently under the care of any doctor other than your pediatrician? Yes No

Name of Doctor: _____

Reason: _____

Medications:

Current: _____

Previous: _____

MEDICAL PRECAUTIONS:

Are there any precautions the therapist should be aware of when working with your child?

Developmental History

Motor milestones: At what age did your child:

Roll: _____ Sit: _____ Pull to stand: _____ Crawl: _____ Walk: _____

Ride a tricycle: _____ Ride a bike: _____ Use writing utensil: _____

Cut with scissors: _____ Feed self: _____ Reach for objects: _____

Drink from cup: _____ Use a Straw: _____ Toilet Training: _____

Speech/Language milestones: At what age did your child:

Did your child babble and coo during infancy? _____

When did your child say his/her first word? _____

When did your child begin to put words together? _____

Does your child speak clearly? Yes No

Do others understand your child? Yes No

Is your child's voice hoarse or husky? Yes No

Describe _____

Does your child Stutter? Yes No

Describe _____

Has your child's speech/language been evaluated prior? Yes No

Where? _____ When? _____

Results? _____

Is your child self conscious about his/her speech? _____

Social History:

How does your child play with other children: please check all that apply:

- Cooperative
- Leader
- Aggressive
- Picked on
- Makes friends easily
- Needs to be in control
- Shares well with others
- Extremely shy

List any concerns you may have about your child's social skills:

Favorite toys/activities: _____

Behavior: Please check all that apply to your child:

- No specific problems
- Easily frustrated
- Difficult to discipline
- Short attention span
- Plays well with others
- Easily distracted
- Self injurious behavior
- Redirects with the following supports: _____

Educational History:

Please list schools attended (include day care and preschools):

Dates attended:

Name/location/district:

Is your child in a special education classroom and/or receiving special education services? _____

Please describe services:

Therapy History:

List any therapy your child has received (When, where, and duration treatment):

Is there any other important information that you feel may be helpful to your child's treatment?

What goals would you like your child to achieve through therapy?

This information will be kept confidential and used solely for the purpose of providing the appropriate care to your child. Thank you.