CLIENT HISTORY FORM

Ages 0-3

☐ **16500 Ventura Blvd. #414 Encino, CA 91436**

☐ **5901 Green Valley Circle, #130 Culver City, CA 90230**

☐ **5300 Santa Monica Blvd., #312 Los Angeles, CA 90029**

(818) 788-1003
(fax) 818 788-1135
www.speechassociates.com

The Information provided on this form will assist us in planning and providing the appropriate services for the client. All information will be a part of the client's record and will be confidential. Information may be stated in our report unless requested that it be kept private. Thank you for your help.

Client's Name: ____

Date of Birth:____ **Age:** ____

Address:

(street and number) (city) (zip)

Home Phone:_____**Cell Phone:**_____**Work Phone:** ____

Mother's Name:_____**Age:**_____**Occupation:** ____

Father's Name:_____**Age:**_____**Occupation:** ____

Siblings' Names and Ages: ____

Child's Doctor:_____**Phone Number:** ____

Doctor's Address: _____

Referral Source: ____

******Is your family covered by insurance? If yes,please complete Health Insurance Information/Release of Information forms attached in the back.***

STATEMENT OF THE PROBLEM

Description of the problem(s):

When was the problem first noticed? ___

What was done about it? *(Please note any previous testing, attach copies of reports, sign release of information*)

What are child's strengths?

What are your expectations from this evaluation?

BIRTH HISTORY

***Pre-natal* care started when:_____**

Gestation period: ____

Specific illnesses:____

Accidents or injuries:____

Medication taken during pregnancy: ____

***Delivery*: a. Duration of labor:_____b. Caesarean section:☐ Yes ☐ No**

c. Breech presentation:☐ Other Info: ____

***Complications of delivery before, during or after:* _a. Infection: _____**

b. Hemorrhage:____ c. C o r d around neck: ____

d. Weight at birth:_____Other Info: ____

DEVELOPMENTAL HISTORY

Neonatal: **(first 30 days of life):**

A.	**Cyanosis (blueness)**	**Yes ☐**	**No ☐**
B.	**Oxygen needed**	**Yes ☐**	**No ☐**
C.	**Jaundice**	**Yes ☐**	**No ☐**
D.	**Paralyses**	**Yes ☐**	**No ☐**
E.	**Feeding difficulties**	**Yes ☐**	**No ☐**
F.	**Infection**	**Yes ☐**	**No ☐**
G.	**Convulsions**	**Yes ☐**	**No ☐**

H. Details of above problems:

DEVELOPMENTAL HISTORY (0 THROUGH 3 YEARS)

Indicate age of occurrence:

A. First rolled over (front to back):___

B. Sat alone:____

C. Crawled: ___

D. Walked:___

E. Toilet training accomplished: ___

F. Hand dominance: Right:_____Left: ___

G. Ride tricycle:_____ Skipped: ___

H. Count to 10:_____ Fed self w/spoon:____

I. Food allergies: ___

J. Sleep habits: ____

MEDICAL HISTORY

A. List specific illnesses and at what age they occurred:

Illness Age

Illness Age

Illness Age

B. Convulsions: Yes: ☐ No: ☐ Age: ____

C. Feeding problems: Yes: ☐ No: ☐

If yes, please explain: ____

D. Accidents:

_____ Age: ____

_____ Age: ____

Please complete the following regarding any medication your child is taking.

Medication	Dosage	Frequency of Administration	Reason for Meds

HEARING, AUDITORY and AUDITORY PROCESSING INFORMATION:

Have you ever questioned your child's ability to hear normally? Yes ☐ No ☐

Explain:

Has your child been given an audiological examination? If yes, state results? ____

Does any member of the family (including aunts, uncles, grandparents) have any hearing, speech or language difficulties? ____

AUDITORY PROCESSING INFORMATION:

My child: (Please answer yes/no to the following statements:)

Yes ☐ No ☐ Follows simple directions correctly
Yes ☐ No ☐ Can determine the main idea of what he/she hears
Yes ☐ No ☐ Listens and waits for his/her turn when talking with others.
Yes ☐ No ☐ Asks questions to check his/her listening.

My child:

Yes ☐ No ☐ Usually remembers what he/she has been told to do.
Yes ☐ No ☐ Remembers things heard in the order they're presented.
Yes ☐ No ☐ Can listen to a story and retell it accurately in own words.

In which listening situations is your child most successful? ___

In which listening situations does your child have the most difficulty? ___

SPEECH AND LANGUAGE DEVELOPMENT

Is there any other language besides English spoken in the home? Yes☐ No ☐

What language?_____What is your child's primary language? ___

Did your child babble during the first 6 months?
Yes ☐ No ☐

When did your child use his/her first words?
___

At what age did your child begin to use sentences?

Which does the child prefer to use? Check all that apply.

- ☐ **Complete sentences**
- ☐ **Multiple word phrases, but not sentences**
- ☐ **Single words**
- ☐ **Unintelligible speech sounds**
- ☐ **Gestures**
- ☐ **Other: Please describe:**

Does your child have difficulty producing specific speech sounds?☐YES ☐NO

If YES, which ones: ____

How well can your child communicate with these people?

	GOOD	FAIR	POOR
PARENTS			
SIBLINGS			
STRANGERS			
PLAYMATES			
TEACHERS			

Is the child's voice too soft?____ Too loud?____

Is speech accompanied by any unpleasant movements or facial expressions?___

Did your child ever acquire speech and then slow down or stop talking? ☐YES ☐NO

How has your child's language-learning difficulties affected the following?

Social interactions with peers: ____

Willingness to talk to others: ____

Participation in the classroom: ____

Academic success: ____

Has your child been previously tested? ☐ Yes ☐ No

If yes, please provide examiner's name and address as well as the report, if available:

PERSONALITY ADJUSTMENT

Does your child tend to play by self or with other children? ____

If with other children, are playmates same age as child?____

Does your child have difficulty concentrating? ____

Is discipline difficult at home? ____

How does your child get along with parents? ____

Is child aware of his/her problem? ____

Reaction of the child to the problem? ____

How has your child's learning difficulties affected the following?

Social interactions with peers: ____

Willingness to talk to others: ____

Participation in the classroom: ____

Does your child often show any of the following behavior patterns?
Check all that apply:

☐ nervousness	☐ whining	☐ temper tantrums
☐ destructiveness	☐ bed wetting	☐ day dreaming
☐ overactive	☐ sluggish	☐ thumb sucking
☐ aggressive	☐ withdrawn	☐ stubborn

For my child to achieve success and self-confidence, I feel his/her most immediate need is: ___

Comments: (Please add any other information which you feel will help the examiner to better understand and work with your child). ___

Person completing this form:_____Date: ___

Please attach copies of past evaluations, or any other information which will help us to better understand your child. Thank you.

FINANCIAL INFORMATION

Client's Name: ____

Contact Person:_____Relationship: ___

Home Phone:_____Work Phone:_____Cell Phone: ___

If any portion of the fees are not covered by insurance or funding agencies, will you be able to meet the cost of this evaluation or treatment? Yes☐ No ☐

INSURANCE INFORMATION (You are responsible for all charges for the evaluation and therapy at the time of each visit. We will, however, be happy to bill your insurance directly and you will be reimbursed by them.)

Name of *PRIMARY* Insurance: _____

Client Name	
Date of Birth	
Subscriber's Name	
Subscriber's Social Security Number	
Name of Subscriber's Employer	
Policy/Contract #	
Group/Control #	
Insurance Address	
Insurance Representative:	
Insurance Phone #:	

Name of *Secondary* Insurance: _____

Client Name	
Date of Birth	
Subscriber's Name	
Subscriber's Social Security Number	
Name of Subscriber's Employer	
Policy/Contract #	
Group/Control #	
Insurance Address	
Insurance Representative:	
Insurance Phone #:	

Please attach a photocopy of your Health Insurance Card(s)

1. **A letter of medical necessity from your physician is required for billing purposes.**
2. **Written pre-authorization of services must be received from your insurance prior to services, if you expect your insurance to pay us directly.**
3. **Payment is expected at the time services are rendered.**
4. **Speech, Language and Educational Associates accepts Visa, MasterCard and AMEX**

..

RELEASE OF INFORMATION FORM

NAME: _____

DOB:_____AGE:_____

DATE: _____

I hereby give my permission to SPEECH, LANGUAGE AND EDUCATIONAL ASSOCIATES to give and to obtain information from the following individual(s) and/or institutions:

NAME ADDRESS PHONE NUMBER

Physician:

School:

Other: _____

Signature:_____Date:_____