



**SLEA**

Speech, Language and Educational Associates

**CLIENT HISTORY FORM**

**Ages 3-5**

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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:** \_\_\_\_\_

**STATEMENT OF THE PROBLEM**

Description of the problem(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was 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: \_\_\_\_\_

c. Breech presentation: \_\_\_\_\_ Other Info: \_\_\_\_\_

*Complications of delivery before, during or after:* a. Infection: \_\_\_\_\_

b. Hemorrhage: \_\_\_\_\_ c. Cord 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. Paralyzes 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: \_\_\_\_\_ J. Skipped: \_\_\_\_\_
- H. Count to 10: \_\_\_\_\_ L. Fed self w/spoon: \_\_\_\_\_
- I. Food allergies: \_\_\_\_\_
- J. Sleep habits: \_\_\_\_\_

**MEDICAL HISTORY**

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

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

**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? \_\_\_\_\_

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:

- \_\_\_\_\_ 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:

	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 group activities: \_\_\_\_\_

Listening in groups: \_\_\_\_\_

Has your child been previously tested? \_\_\_\_\_ If yes, please provide examiner's name and address as well as the report, if available: \_\_\_\_\_

**HEARING, AUDITORY and AUDITORY PROCESSING INFORMATION:**

Have you ever questioned your child's ability to hear normally? \_\_\_\_\_

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:**

**Listening Carefully** My child: (Please answer yes/no to the following:)

- \_\_\_\_\_ follows simple directions correctly.
- \_\_\_\_\_ can determine the main idea of what he/she hears.
- \_\_\_\_\_ listens and waits for his/her turn when talking with others.
- \_\_\_\_\_ asks questions to check his/her listening.

**Remembering** My child:

- \_\_\_\_\_ usually remembers what he/she has been told to do.
- \_\_\_\_\_ remembers things heard in the order they're presented.
  
- \_\_\_\_\_ can listen to a story and retell it accurately in his/her own words.

**In which listening situations is your child most successful?** \_\_\_\_\_

\_\_\_\_\_

**In which listening situations does your child have the most difficulty.** \_\_\_\_\_

\_\_\_\_\_

**EDUCATIONAL HISTORY:**

**What preschool does the child attend?** \_\_\_\_\_

**Teacher's name:** \_\_\_\_\_

**School's Address & Phone Numer:** \_\_\_\_\_

\_\_\_\_\_

**Please describe your child's preschool difficulties, (if any ):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are there discipline problems in school?** \_\_\_\_\_ **If yes, please describe:** \_\_\_\_\_

\_\_\_\_\_

**Does your child like school?** \_\_\_\_\_ **Does the child like his/her teacher:** \_\_\_\_\_

**Does child listen to books for pleasure?** \_\_\_\_\_ **If so, what level of books?** \_\_\_\_\_

**List some of your child's favorite books:** \_\_\_\_\_

\_\_\_\_\_

Are there behavioral difficulties at school? \_\_\_\_\_

If yes, please describe; \_\_\_\_\_

Has your child's behavior been previously addressed? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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 language 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.**