CLIENT HISTORY FORM

Ages 5-18

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CLIENT HISTORY FORM

Ages 5-18

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) (please attach copies of reports)*** _____

_____

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. Hemerrhage: _____ **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.	**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 FIVE 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

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. _____

_____

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 the classroom: _____

_____

Academic success: _____

_____

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

_____

EDUCATIONAL HISTORY

What school does the child attend? _____

Grade? _____**Teacher:** _____

School's Address & Phone Numer: _____

_____

Skipped any grades? _____**Repeated grades?** _____

Please describe your child's academic difficulties (if any): _____

_____

_____

_____

Best school subjects: _____

Most difficult school subjects: _____

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

_____

_____

Has your child been previously tested? _____**If yes, please provide examiner's name and address:**

_____

_____

Please read through this list and check items that your have noted to occur frequently

_____**Frequent word recognition errors**

_____**Frequent applied spelling errors**

_____ **Confuses minor likenesses and differences**

_____**Difficulty copying from the chalkboard**

_____ **Difficulty completing written assignments in the time allotted**

_____ **Poor printing or handwriting**

_____ **Reverses letters or numbers**

_____ **Poor ability to remember what is read**

_____ **Repeatedly confuses right-left directions**

_____ **Poor recall of visually-presented tasks**

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 <u>often</u> 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, report cards or any other information which will help us to better understand your child. Thank you.