CLIENT HISTORY FORM

All information provided in this questionnaire will remain confidential.

Today's Date .....
Child's Name ..... Sex ..... Date of Birth .....
Address .....
City ..... State ..... Zip .....
Telephone ..... Cell phone .....
Email address(es) .....
Can we contact you by email? ☐ Yes ☐ No
1st Parent/Guardian Name ..... Occupation .....
Address (if different from above)
.....
.....
2nd Parent/Guardian Name ..... Occupation .....
Address (if different from above)
.....
.....
Who referred child for services? .....
Family Physician (or physician who knows this child best) .....
Physician address ..... Phone .....
Name of child's school (if applicable) .....
Has the child had any previous speech/language therapy? ☐ Yes ☐ No
If yes, when and with whom? .....
Is this child receiving speech/language therapy currently? ☐ Yes ☐ No
If yes, with whom? .....

SPEECH HISTORY

Describe fully the reason(s) for referral .....
.....
.....
Are you aware of any factors (e.g., physical, emotional, or environmental) that might have contributed to his/her communication difficulty? ☐ Yes ☐ No

If yes, please describe .....
.....
Please describe any developmental issues in addition to the communication problem your child may have .....
.....
.....
How does your child usually communicate? (check all that apply):
☐ pointing ☐ gestures ☐ short phrases
☐ sounds ☐ single words ☐ sentences
Is your child able to understand (check all that apply):
☐ gestures ☐ words ☐ short phrases ☐ sentences
When was the difficulty first noticed? ..... (by parents) ..... (by child)
Has the difficulty changed since it was first noticed? If so, please describe
.....
.....
How have caregivers tried to help the child's communication difficulty?
.....
.....
Where or with whom does the child find it easiest to communicate?
.....
.....
Most difficult? .....
Birth History (To the best of your knowledge)
.....
.....
Did the child's mother have a physician's care before the child's birth?
☐Yes ☐No If so, for how long? .....
Were there illnesses or unusual events that occurred during this pregnancy? .....
Was labor and delivery normal? .....
Was the child full term? ☐Yes ☐No Birth weight .....
Was help needed to start the baby breathing or nursing, or to continue it?
.....
Describe any birth abnormalities among this child's siblings
.....
.....

{ DEVELOPMENTAL HISTORY }

To the best of your recollection, at what age was the child able to:
Hold up head while lying on stomach ..... Sit unsupported .....
Walk unassisted ..... Feed self with a spoon .....
Dress self (except tying shoes) .....
At what age was toilet training completed? .....
Has the child had any feeding difficulties? ☐ Yes ☐ No
If yes, please describe .....
Was the above information supplied from memory or baby records?
.....
.....
If sleep has ever presented a problem, please describe
.....
.....
Did child suck thumb or use a pacifier? .....
If so, at what age did he/she stop? .....

{ MEDICAL HISTORY }

List any physical handicaps the child has
.....
.....
Is the child taking medication? ☐ Yes ☐ No
If yes, for what reason? .....
Does child wear glasses? ☐ Yes ☐ No
If yes, for what reason? .....
When was the child's hearing last tested? ..... Results .....
Did the child ever lose hearing (even for a short time)? ☐ Yes ☐ No
If yes, when? .....
Does he/she seem to hear better in some places than others? .....
Does he/she understand you when he/she is not watching your face? .....
What operations has your child had? .....
Does child have a history of any of the following?

☐ Tonsilitis	☐ Frequent colds	☐ Ear infection
☐ Asthma	☐ High fevers	☐ Allergies

Were there any after effects from the above illnesses? If so, please explain:.....
.....
At what ages (to the best of your knowledge), did the child demonstrate the following speech behaviors (if applicable):

Imitated sounds ….. Said first words ….. Stuttered …..
Followed verbal directions ….. Put 2-3 words together …..
Enjoyed listening to a story ….. Talked in full sentences …..
Told a simple story accurately ….. Stopped talking for a period …..

{ FAMILY AND SOCIAL HISTORY }

List adults who live in the child's home and their relationship to the family.....
.....
List any other children in the home:

Name	Sex	Age	Relationship
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Do any of the above have speech/language difficulties? If so, please describe.....
.....
What is the primary language spoken in the home? .....
Are there other languages spoken in the home? ☐ Yes ☐ No
If yes, what language(s) and by whom? .....
Do any relatives have speech/language difficulties? ☐ Yes ☐ No
If yes, please describe .....
How does the child get along with siblings (if applicable)?
.....
Does this child have playmates of his/her own age? ☐ Yes ☐ No
Does he/she prefer to play with:
☐ same age children ☐ older children ☐ younger children
Describe how he/she plays with other children
.....
What are his/her favorite activities or games? .....

Does he/she play contentedly by him/herself? .....
At what activities? .....
Does he/she prefer to be with children or adults? .....
Does he/she avoid social activities in his/her own age group? .....

{ SCHOOL HISTORY-- if applicable }

At what age did schooling begin? .....
In what grade is the child enrolled? .....
Has school seemed to help child's speech/language problem? .....
Has it made it worse? .....
Does child like school? ☐Yes ☐No
What subjects does he/she find difficult? .....
Has the child had problems in school? ☐Yes ☐No
Please describe .....

Please return this completed questionnaire to the clinician along with:

1) *photocopies of any relevant assessments that your child has had (e.g., hearing/vision testing, academic evaluation, psychological evaluation, previous speech/language assessments, occupational therapy evaluation, etc.)*
2) *a completed Communication Therapy Consent Form, which will allow the clinician to communicate with the child's physician, teacher(s), and therapeutic team when applicable. This Consent Form can be obtained from the clinician directly or by downloading it at www.communicationtherapy.net.*

Thank you very much for taking the time to fill out this lengthy questionnaire. The information you have provided will be extremely useful in helping the clinician evaluate and/or design an intervention program for your child. If there is any additional information you would like to add, please do so below:

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