NKY SPEECH THERAPY

NEW CLIENT INFORMATION

Client's Name: _____ Date: _____

Date of Birth: _____ Age: _____ Medicaid# or SSN#_____

Address (street, city, zip): _____

Telephone: _____ E-mail:_____

Mother's Name: _____ SS#:_____

Occupation: _____Employer: _____

Business Telephone:_____ Cell:_____

Father's Name: _____ SS#:_____

Occupation: _____ Employer: _____

Business Telephone:_____ Cell:_____

Are both mother and father living in the home? _____

Primary language spoken in the home: _____ Second language: _____

Siblings:

Name	Birth date	Age / Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do all siblings live in the same home? _____

Other persons in home:

Name	Relationship to child

_____ _____

_____ _____

Pediatrician: _____ Address:_____Ph#_____

Medications: _____Allergies:_____

Emergency Contact: _____

REASON FOR REFERRAL:

What are your main concerns about the child?

_____

_____

How does the child usually communicate (gestures, single words, short phrases, sentences)?

_____

_____

Is the child aware of his/her speech/language and/or motor issues? If yes, how does the child feel about it?

_____

_____

Has the child received speech therapy or occupational therapy in the past? If yes, indicate the name of the specialist, when the child was seen, and the specialist's conclusions or suggestions.

_____

_____

Have any other specialist seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

_____

_____

Are there any other speech, language, learning, hearing or motor concerns in your family? If yes, please describe.

_____

_____

BIRTH HISTORY

Length of Pregnancy: _____ Mother's age at birth of child: _____

What pregnancy was this child? _____

Describe the mother's general health during the pregnancy (illnesses, accidents, medications, etc.):

_____

_____

Were there any unusual conditions that may have affected the pregnancy or birth?

_____

_____

Length of hospital stay: Mother: _____

Child: _____

Were there any complications after birth?

_____

_____

MEDICAL HISTORY

What specific diagnoses, if any, have been made by a physician?

_____

_____

Describe any major accidents, surgeries, or hospitalizations:

_____

_____

Is the child currently taking any medications? If yes, identify.

_____

_____

Has the child had any of the following (please circle):

Seizures Ear Infections High fevers Asthma Allergies

If circled, please explain:

_____

_____

_____

Please provide information regarding the child's last hearing screening (i.e., date, doctor's name, results):

_____

List any other medical professionals involved with the child (including family doctor):

Name	Profession	Phone Number
_____	_____	_____
_____	_____	_____

SOCIAL / BEHAVIOR:

Please circle any of the following that apply to the child:

Bedwetting
Temper tantrums
Bites self / objects / others
Head banging
Toe-walking
Staring spells
Difficult with changes (activities / people)
Sleeping problems
Eating problems
Unreasonable fears / worries
Tics / nervous habits
Repetition of activities
Hurts self on purpose
Separation Difficulties (from parent)
Unusual physical movement
Hand Flapping
Preoccupation with certain objects
Trouble getting along with others
Short attention span

SENSORY / MOTOR:

Please circle any of the following that apply to the child:

Touch:
Fearful of having face washed
Aggressive if others are too close
Dislikes being barefoot
Tries to touch everyone / everything
Insists on holding an object in hand
Does not respond to pain

Hearing:
Seems overly sensitive to sound
Unable to hear whispers
Speaks loudly
Ignores sounds / certain noises

Vision:
Overly sensitive to bright light / sunlight
Follows moving objects
Searches for removed or hidden objects
Squints eyes
Tilts head to look at things

Please circle any of the following that apply to the child:

Movement / Coordination:
Rocks body
Jumps uncontrollably
Seeks rough and tumble play
Likes fast moving / spinning activities
Is hesitant at stairs / curbs
Bumps into things / accident prone
Fearful when feet are off the ground

Taste / Smell:
Mouths objects
Avoids certain textures of food
Smells objects inappropriately
Overly sensitive to smell
Drools
Difficulty chewing / swallowing
Eats only soft foods

DEVELOPMENTAL HISTORY

Describe any problems during infancy (difficulty with sucking, swallowing, eating solid foods, sleeping, irritability, etc.):

_____

_____

Provide the approximate age at which the child began to do the following activities:

Crawl: _____ Sit: _____ Stand: _____

Walk: _____ Feed self: _____ Dress Self: _____

Use toilet: _____

Use single words (e.g., no, mom, doggie, etc.): _____

Combine words (e.g., me go, daddy shoe, etc.): _____

Name simple objects (e.g., dog, car, tree, etc.): _____

Use simple questions (e.g., Where's doggie, etc.): _____

Engage in conversation: _____

Describe the child's response to sound (e.g., responds to all sounds, responds only loud sounds, inconsistently responds to all sounds, etc.).

_____

_____

EDUCATIONAL HISTORY

School: _____ Grade: _____

Teacher(s): _____

How is the child doing academically (or preacademically)?

_____

_____

How does the child interact with others (e.g., shy, aggressive, uncooperative, etc.)?

_____

_____

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals (or attach a copy of current IEP).

_____

_____

_____

Provide any additional information that might be helpful in the evaluation or remediation of the child's needs.

_____

_____

_____

Person completing form: _____

Relationship to child: _____

How were you referred to our office? _____

Signed: _____ Date: _____