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Client Information

Date completed: _____

Person completing this form:_____

Relation to the child:_____

Child's Name:_____Birthdate:_____Sex: ❑M ❑F

Father's Name:_____Daytime Phone:_____

Address:_____Cell Phone:_____

E-mail:_____Occupation:_____

Mother's Name:_____Daytime Phone:_____

Address:_____Cell Phone:_____

Email:_____Occupation:_____

Physician:_____Physician's Phone:_____

Doctor's Address:_____

Doctor's Fax:_____

Do you have medical insurance: ❑Yes ❑No If yes, which parent is the primary insured?

❑ Mother ❑Father

Insurance Provider:_____ Ins Phone Number:_____

Insurance ID Number:_____ Group Number:_____

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Child lives with (check one):

- ❑ Birth Parents
- ❑ Adoptive Parents
- ❑ Foster Parents
- ❑ Parent and Step-Parent
- ❑ One Parent
- ❑ Other

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Child's race/ethnic group:

- ❑ Caucasian, Non-Hispanic
- ❑ Native American
- ❑ Hispanic
- ❑ Asian or Pacific Islander
- ❑ African-American
- ❑ Other ____

Is there a language other than English spoken in the home? ❑Yes ❑No

If yes, which one?_____

Does the child speak the language? ❑ Yes ❑ No

Does the child understand the language? ❑ Yes ❑ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

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Speech-Language-Hearing
Feeding - Swallowing

Please describe your concerns about your child's development.

_____

_____

_____

When did you first notice your child's speech, language or motor condition?_____

_____

_____

What is your child's primary mode of communication? Please describe.

❑ Verbal
❑ Facial expressions
❑ Vocalizations / grunting
❑ Points/ directs/ gestures
❑ AAC device
❑ Other

Did your child: If not please list at what age each emerged.

Babble / Coo by 4 months ❑ Yes ❑ No
Respond to name / peek a boo by 8 months ❑ Yes ❑ No
Imitate sounds / use jargon by 12 months ❑ Yes ❑ No
Say first words by 15 months ❑ Yes ❑ No
Say 2 word combos by 24 months ❑ Yes ❑ No
Use short sentences by 36 months ❑ Yes ❑ No

Any family history or speech, language, hearing, motor difficulty? Please Describe_____

_____

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Any history of a hearing problem? ❑ Yes ❑ No

If yes, please describe. _____

Has your child been diagnosed w/ a medical condition? Explain _____

_____

_____

Has he/she ever had a speech evaluation/screening? ❑ Yes ❑ No

If yes, where and when /results? _____

Has he/she ever had a hearing evaluation/screening? ❑ Yes ❑ No

If yes, where and when / results? _____

Has your child ever had speech therapy? ❑ Yes ❑ No

If yes, where and when? _____

Has your child received any other evaluation or therapy (physical therapy, counseling occupational therapy, vision, etc.)? ❑ Yes ❑ No

If yes, please describe where and for how long. _____

What progress has been made / please describe. _____

_____

_____

Is your child aware of, or frustrated by, any speech/language difficulties? _____

What do you see as your child's most difficult problem outside of the home? _____

What do you see as your child's most difficult problem is? _____

Does your child have allergies (environmental or food)? _____

How would you characterize your child's diet?

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❑ **Regular** (all food allowed, no allergies or restrictions)

❑ **Regular** (w/ the exceptions: list food allergies / dietary restrictions)_____

❑ **Puree** (requires very little chewing)

❑ **Mechanical soft** (requiring some chewing)

❑ **Advanced** (requires more chewing but sift foods)

Does your child self feed? ❑Yes ❑No

Was your child ever on a vent? If so, for how long? _____

Was your child breast fed, bottle fed or tube fed? ❑Yes ❑No Please list_____ When was your child first given a bottle?_____

Any problems w/ nursing or bottle feeding? (poor suck, slow to feed, choking) ❑Yes ❑No Did your child use a pacifier and for how long?_____

Does your child use a sippy cup or another type of cup?_____

When did your child first eat solids?_____

List foods and liquids your child will or will not eat/drink.

Likes	Dislikes
_____	_____
_____	_____
_____	_____
_____	_____

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Does your child gag, spit out food, vomit or hold food / liquid in his / her mouth during meal / snack time? ❑Yes ❑No

How many times per day does your child eat? _____

Who feeds your child (parents, other family, daycare providers, etc.)
_____

How is your child positioned when eating (high chair, sitting on floor, sitting on someone's lap, etc.)?
_____

Does your child take any medications / supplements: If so, please list? _____
_____
_____

Check the following descriptions of behaviors/actions that are consistently exhibited (at least once per week) at the mealtime

❑ a poor appetite
❑ disinterest in food
❑ food refusal
❑ extreme food
❑ pickiness
❑ talks with mouth full
❑ gagging with or without vomiting
❑ mealtime tantrums
❑ unusual food habits
❑ food-texture selectivity
❑ excessive overeating
❑ yells
❑ whining or fussing at mealtimes
❑ requests for non-served foods
❑ takes food from another's tray/plate
❑ gets out of seat
❑ easily distracted from eating
❑ throws food
❑ messy eating
❑ frequent spills
❑ has ability, but doesn't use napkin
❑ prefers liquids over solid food
❑ poor eye contact with communication partner or feeder
❑ doesn't keep hands to self
❑ eats too fast
❑ eats too slow
❑ doesn't orient to feeder
❑ but orients at other times
❑ expelling of food
❑ takes bites that are too large
❑ exhibits self-stimulatory behavior at mealtime
❑ talks too much at mealtime
❑ takes bites that are too small
❑ drinks too fast
❑ ignores communication partner/feeder
❑ chews with mouth open

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Check the following reactions that have been observed with eating:

❑ Coughing: How often per week, month, etc.?
❑ Gagging: How often per week, month, etc.?
❑ Slow eating: How often per week, month, etc.?
❑ Choking: How often per week, month, etc.?
❑ Wet vocal quality: How often per week, month, etc.?
❑ Noisy breathing associated with feeding How often per week, month, etc.?
❑ Upper respiratory infections, pneumonias, etc. How often in the past year?
❑ Other physical signs associated with eating (i.e., heart rate, color changes, respiratory changes, weight loss, etc.): Describe what has been observed and how often it has occurred in the past year_____

_____

❑ Hospitalizations in the past year? Why? How long? _____

Birth History

Was there anything unusual about the pregnancy or birth? ❑ Yes ❑ No

If yes, please describe. _____

_____

_____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ❑ Yes ❑ No

If yes, please describe. _____

_____

How many months was the pregnancy?_

Did the child go home with his/her mother from the hospital? ❑ Yes ❑ No

If child stayed at the hospital, please describe why and how long.

_____

_____

_____

_____

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Medical History

Has your child had any of the following?

- ❑ adenoidectomy
- ❑ allergies
- ❑ breathing difficulties
- ❑ encephalitis
- ❑ flu
- ❑ head injury
- ❑ seizures
- ❑ sinusitis
- ❑ sleeping difficulties

- ❑ chicken pox
- ❑ colds
- ❑ ear infections
  How often?_____
- ❑ ear tubes
- ❑ low birth weight
- ❑ high fevers
- ❑ measles
- ❑ meningitis
- ❑ mumps
- ❑ scarlet fever
- ❑ hyperactivity
- ❑ thumb/finger sucking habit
- ❑ tonsillectomy
- ❑ tonsillitis
- ❑ vision problems
- ❑ frequent colds
- ❑ gastric reflux

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? ❑ Yes ❑ No

If yes, why?_____

_____

Please list any medications your child takes regularly: _____

_____

_____

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Motor Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____held up head
_____ crawled
_____ walked
_____fed self
_____potty-trained
_____sat alone
_____grasped crayon/pencil
_____toilet trained
_____used scissors
_____brush own teeth

Is your child right or left-handed_____?

Does your child have difficulty w/ any of the following pending age appropriateness?

- ❑ Zippers / buttons
- ❑ Hopping / jumping
- ❑ Dressing
- ❑ Pulling to sit or stand
- ❑ Handwriting
- ❑ Lifting head while on stomach
- ❑ Accepting weight into legs
- ❑ Throwing a ball overhand
- ❑ Rolling over
- ❑ Standing at furniture
- ❑ Walking / running/ jumping
- ❑ Sitting alone
- ❑ Standing alone
- ❑ Walking up and down steps
- ❑ Bringing hands together at midline
- ❑ Transferring object from hand to hand
- ❑ Building tower w/ blocks
- ❑ Copying / tracing
- ❑ Cutting
- ❑ Balancing / hopping on one foot

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Current Speech-Language-Hearing

Does your child...

- ❑ repeat sounds, words or phrases over and over?
- ❑ understand what you are saying?
- ❑ retrieve/point to common objects upon request (ball, cup, shoe)?
- ❑ follow simple directions ("Shut the door" or "Get your shoes")?
- ❑ respond correctly to yes/no questions?
- ❑ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

- ❑ body language.
- ❑ sounds (vowels, grunting).
- ❑ words (shoe, doggy, up).
- ❑ 2 to 4 word sentences.
- ❑ sentences longer than four words.
- ❑ other_____.

Behavioral Characteristics:

- ❑ cooperative
- ❑ attentive
- ❑ willing to try new activities
- ❑ plays alone for reasonable length of time
- ❑ separation difficulties
- ❑ easily frustrated/impulsive
- ❑ stubborn
- ❑ overly active
- ❑ avoids group play
- ❑ sleep difficulties
- ❑ restless
- ❑ poor eye contact
- ❑ easily distracted/short attention
- ❑ destructive/aggressive
- ❑ withdrawn
- ❑ inappropriate behavior
- ❑ self-abusive behavior
- ❑ falls / trips easily
- ❑ prefers to play alone

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School History

If your child is in school, please answer the following:

Name of school and grade in school:

_____

Teacher's name:_____

Has your child repeated a grade? _____

What are your child's strengths and/or best subjects? _____

Is your child having difficulty with any subjects? _____

Is your child receiving help in any subjects?

_____

Additional Comments

I have filled out this form to the best of my knowledge and have disclosed all pertinent information necessary for therapy services rendered by Altruistic Therapy Services. I also certify that I am the legal guardian and that I can exercise all the parental rights for the said child.

_____ _____

Parent signature Date

_____ _____

Parent signature Date