

SPEECH PATHways

Client History

Client's Full Name: _____

Name by which client is called: _____

Date of Birth: _____ Age: _____

Home
Address: _____

Client's Home Phone
Number: _____

Cell Phone
Number: _____

What language(s) is/are spoken at home? _____

Who referred you to SPEECH PATHways? _____

What are your concerns that bring you to SPEECH PATHways? _____

Have you discussed these concerns with your child's doctor or teacher? _____

List any medical diagnoses the child has: _____

What do you hope to accomplish by coming to Speech PATHways? _____

Has your child in the past or does he/she currently use an augmentative communication device or any assistive technology at home or at school? Yes _____ No _____

If he/she has used in the past only, briefly explain why he/she is not currently using: _____

Who evaluated your child for the augmentative communication device or assistive technology? _____

FAMILY INFORMATION

Name of Mother: _____ Languages Spoken: _____

Address: _____

Occupation: _____ Education Level: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____ E-Mail: _____

Name of Father: _____ Languages Spoken: _____

Address: _____

Occupation: _____ Education Level: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____ E-Mail: _____

With whom does your child live? (List in table below)

Name	Age	Sex	Speech Problem?	Remarks

COMMUNICATION STATUS

How would you describe the client's current communication ability? (Check all that apply)

- Almost never communicates
- Sometimes communicates
- Communicates frequently

- Is very easy for me to understand when I know the topic of conversation
- Is fairly easy for me to understand when I know the topic of conversation
- Is difficult for me to understand when I know the topic of conversation

- Is very easy for me to understand if I don't know the topic of conversation
- Is fairly easy for me to understand if I don't know the topic of conversation
- Is difficult for me to understand if I don't know the topic of conversation

- Is usually understood by other people who don't know him/her well
- Is usually NOT understood by other people who don't know him/her well

In your own words, please describe how your child communicates: _____

Indicate the extent to which you agree with the following statements: (circle one)

Your child is able to communicate effectively to express pleasure or displeasure.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

Your child can communicate to get help when needed.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

Your child's biggest communication need is to ask for things he/she needs.

Strongly Disagree Disagree Not Sure Agree Strongly Agree

Your child's biggest communication priority is to get or give information (e.g. ask or answer questions).

Strongly Disagree Disagree Not Sure Agree Strongly Agree

What words, if any, does your child say? _____

What words, if any, does your child write? _____

What gestures does your child make (e.g. pointing, motioning to "come here", and tugging for attention)? When does he/she use these gestures? _____

Briefly describe a typical day for your child: _____

Please list any of your child's achievements that are especially important to him/her or you: _____

What manual signs (or sign language) does your child use? When does he/she use these signs? _____

What other things does he/she do to communicate (e.g. Look at something he/she wants, blinks eyes)? _____

THERAPUTIC INFORMATION

Please list some things your child really likes and dislikes:

FOODS		PEOPLE		TV SHOWS	
Likes	Dislikes	Likes	Dislikes	Likes	Dislikes
PLACES		THINGS TO DO		OTHER	
Likes	Dislikes	Likes	Dislikes	Likes	Dislikes

Please list any special interests or hobbies your child has: _____

PRENATAL AND BIRTH HISTORY

Check any of the factors below that apply:

During Pregnancy

- | | | |
|---|---|--|
| <input type="checkbox"/> Excessive vomiting | <input type="checkbox"/> Hemorrhaging | <input type="checkbox"/> X-ray treatments |
| <input type="checkbox"/> Illnesses (i.e., German measles) | <input type="checkbox"/> Medications | <input type="checkbox"/> RH incompatibility |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Smoking | <input type="checkbox"/> Previous miscarriages |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Trauma/injuries | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Excessive weight loss | <input type="checkbox"/> Excessive weight gain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Premature rupture of membranes | <input type="checkbox"/> Need for hospitalization or bed rest | |

MEDICAL HISTORY

	Age	Mild	Mod.	Severe		Age	Mild	Mod.	Severe
Allergies					Heart Problems				
Asthma					Meningitis				
Convulsions/ Seizures					Muscle Disorder				
Dental Problems					Nerve Disorder				
Encephalitis					Pneumonia				
Headaches					Vision Problems				
Head Injuries									
Ear Infections									

Describe any other illnesses, accidents, injuries, operations, and hospitalizations: _____

Does your child use a wheelchair or assistive walking device? _____

SPEECH AND LANGUAGE DEVELOPMENT

Indicate when your child first demonstrated the following:

<u>Age</u>	<u>Behavior</u>	<u>Age</u>	<u>Behavior</u>
___	Cooing, pleasure sounds	___	Single words
___	Babbling (ba-ba, da-da, etc.)	___	Phrases (go bye-bye, more juice)
___	Jargon (talking own special language)	___	Short sentences

What is the primary method(s) your child uses for letting you know what he/she wants?

___	Looking at objects	___	Pointing at objects	___	Gestures
___	Crying	___	Vocalizing/grunting	___	Physical manipulation
___	Single words	___	2-3 word combinations	___	Sentences

Which of the following best describes your child's speech?

- ___ Easy to understand
- ___ Difficult for parents to understand
- ___ Difficult for others to understand
- ___ Almost never understood by others
- ___ Different from other children of the same age

Which of the following statements best describes your child's reaction to his/her speech?

- ___ Is easily frustrated when not understood
- ___ Does not seem aware of speech/communication problem
- ___ Has been teased about his/her speech
- ___ Tries to say sounds or words more clearly when asked
- ___ Is successful in saying sounds or words more clearly when he/she tries

Is your child aware of his/her communication difficulties? ___ Yes ___ No

If "yes", how does this awareness impact your child's social/emotional status? _____

Does your child have difficulty producing certain sounds? ___ Yes ___ No

If "yes", which ones? _____

Does your child hesitate and/or repeat sounds or words? ___ Yes ___ No

Does your child "get stuck" when attempting to say a word? ___ Yes ___ No

Do you have concerns about your child's voice? Yes No

Which of the following do you think your child understands?

His/her own name Names of body parts Family names
 Names of objects Simple directions Complex directions
 Conversational speech

MOTOR DEVELOPMENT

At approximately what age did your child achieve the following motor milestones?

Head support <input type="checkbox"/>	Reach & grasp <input type="checkbox"/>	Sitting alone <input type="checkbox"/>
Crawling <input type="checkbox"/>	Standing alone <input type="checkbox"/>	Walking alone <input type="checkbox"/>
Climbing stairs <input type="checkbox"/>	Finger foods <input type="checkbox"/>	Eat with a spoon <input type="checkbox"/>
Potty trained <input type="checkbox"/>	Undressed self <input type="checkbox"/>	

Is your child overly awkward or clumsy? Yes No

Does your child display a hand preference? Yes No

If "yes", which hand does your child prefer to use? Right Left

Has your child had any feeding difficulties? Check each item that applies.

Sucking or nursing
 Excessive length of time to drink bottle
 Regurgitation of liquids or solids through the nose
 Difficulty chewing or swallowing meats
 Chocking and/or gagging

Does your child choke while eating? Yes No

If "yes", on what foods? _____

Is your child a picky eater? Yes No

If "yes", what foods does he/she prefer? _____

Describe any feeding problems your child experienced during the first three months of life: _____

Does your child drool more than other children his/her age? ___ Yes ___ No

Did your child have difficulty gaining weight as an infant? ___ Yes ___ No

Does/Did your child use a pacifier? ___ Yes ___ No

Does/Did your child suck their thumb? ___ Yes ___ No

Check these as they apply to your child:

	Yes	No	If yes, explain & give ages if possible
Eating problems			
Sleeping problems			
Toileting problems			
Difficulty concentrating			
Needs a lot of structure			
Interactive			
Excitable			
Laughs easily			
Cries a lot			
Difficult to manage			
Overactive			
Sensitive			
Personality problems			
Gets along with others			
Emotional			
Stays with an activity			
Makes friends easily			
Happy			
Irritable			

PLAY BEHAVIORS

Which of the following describes the type of play your child likes to engage in the most often?

- | | | |
|----------------------------------|---------------------------|-------------------------|
| ___ Putting toys in mouth | ___ Banging toys together | ___ Throwing toys |
| ___ Shaking toys | ___ Pushing/pulling toys | ___ Role-playing |
| ___ Uses one object for another | ___ Games with rules | ___ Rough & tumble play |
| ___ Appropriate use of objects | ___ Make believe play | ___ Looking at books |
| ___ Acting out familiar routines | | |

What is the average length of time your child can stay playing at one activity? _____

Which activities seem to hold your child's attention for the longest period of time? _____

Which activities seem to hold your child's attention for the shortest period of time? _____

Is your child's play easily distracted by any of the following?

- Visual stimuli (i.e., other toys or objects)
- Auditory stimuli (i.e., voices, sounds outside, the TV)
- Nearby activities
- Other people in the room

Whom does your child prefer to play with? (Circle ones that apply)

Mother Father Brother/Sister Self Other Child Other Adult

List some of your child's favorite toys, TV programs and videos: _____

SOCIAL/EMOTIONAL DEVELOPMENT

Check behaviors that you feel best describes your child:

- | | |
|---|--|
| <input type="checkbox"/> Overly active | <input type="checkbox"/> Defiant |
| <input type="checkbox"/> Overly quiet | <input type="checkbox"/> Easily controlled/Passive |
| <input type="checkbox"/> Excessive tantrums | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Dependent upon routines |
| <input type="checkbox"/> Very shy | <input type="checkbox"/> Difficulty separating from parent |
| <input type="checkbox"/> Perfectionistic | <input type="checkbox"/> Thumb-sucking |
| <input type="checkbox"/> Friendly, outgoing | <input type="checkbox"/> Drooling |
| <input type="checkbox"/> Imaginative and creative | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Plays well with other children | <input type="checkbox"/> Mouth breather |
| <input type="checkbox"/> Prefers older children | <input type="checkbox"/> Interrupted/Unusual eating habits |
| <input type="checkbox"/> Prefers younger children | <input type="checkbox"/> Interrupted/Unusual sleeping habits |

Describe any discipline problems you have with your child: _____

Describe any evaluations or therapy for behavior or emotional problems: _____

What method of discipline do you use? _____

What method of discipline does your spouse use? _____

EDUCATIONAL HISTORY

Educational Setting	Location/School	Teacher(s)
Child Care Facility		
Early Childhood Classes		
Birth to 3 Programs		

How often does your child attend classes?

Daily 4 Times per week 3 Times per week
 2 Times per week 1/2 Days Full day

How many children are in your child's class? _____

What type of classroom is your child in? (i.e., traditional, open classroom, transdisciplinary, etc.) _____

Does your child exhibit any learning style preferences? Visual Auditory Both

Does your child's developmental performance seem to interfere with his/her school performance? Yes No

If "yes", please explain: _____

Have teachers expressed any concerns about your child's learning behavior? ___ Yes ___ No

If "yes", please describe: _____

Has your child ever been evaluated for or attended therapy for:

___ Speech problems ___ Vision problems ___ Feeding problems
___ Hearing problems ___ Physical motor problems
___ Other

Please give locations, dates, and results: _____

What other services does your child have now? What has he/she had in the past?

Type of service	Has Now	Had Before
Physical Therapy		
Occupational Therapy		
Speech-Language Therapy		
Psychological or Behavioral Counseling		
Nutritional Services		
Other (describe)		

HEARING HISTORY

Does your child have a history have a history of ear infections or otitis media? ___ Yes ___ No

How many occurrences of ear problems? _____

At what age? _____ Age of onset? _____

How long did each ear problem last? _____

What treatments (medications) were prescribed? _____

Has your child ever been treated by an ear, nose, throat specialist? ___ Yes ___ No

Who? _____ When? _____

Does your child say “huh” or “what” at least five or more times a day? ___ Yes ___ No

Do you ever question your child’s ability to hear normally? ___ Yes ___ No

If “yes”, please explain: _____

Is your child easily distracted? ___ Yes ___ No

Does your child have difficulty following directions? ___ Yes ___ No

When was the last time your child’s hearing was checked?
___ Within the last year
___ 1-3 years ago
___ 4 or more years ago

INSURANCE INFORMATION

Do you have insurance? ___ Yes ___ No

If "yes", company name: _____

Policy Number: _____

Does your insurance cover speech-language evaluations? ___ Yes ___ No

Does your insurance cover speech-language therapy? ___ Yes ___ No

Is your insurance a HMO? ___ Yes ___ No Is your insurance a PPO? ___ Yes ___ No

Who is responsible for your child? _____

Relationship? _____

Child's Doctor: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____