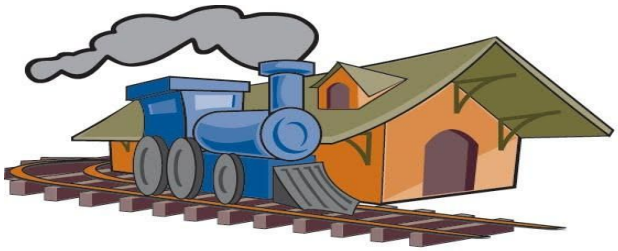

COMMUNICATION STATION LLP
Pediatric Speech-Language Therapy

Client Information Sheet

Date: _____ Client Full Name: _____

Date of Birth: ___/___/___ Age: _____ Sex: ___

Telephone: Home #: _____ Cell#: _____

Home Address:

_____

Mother's Name:

_____

Father's Name:

_____

Sibling's/Ages:

_____

Primary Care Physician: _____ Phone #: _____

Others Living in the Home:

_____

Languages Spoke in the Home:

_____

WHO IS RESPONSIBLE FOR THE CLIENT'S BILLS?

_____

Address: _____

City: _____ State: _____ Zip: _____

1997 Route 17M #9 • Goshen, New York 10924
Phone: (845)294-4787 • Fax: (845)294-4790 • SLP@communicationstationny.com

Phone#: _____

Date of Birth: ___/___/___ Employer:_____

Phone # of Employer: _____

Address of Employer: _____

WHOM MAY I CONTACT IN THE EVENT OF AN EMERGENCY (OTHER THAN PARENT)?

Name: _____

Telephone #: _____

Relationship: _____

WHO CAN I THANK FOR REFERRING YOU:

_____

BIRTH HISTORY

Pregnancy:

Age of Mother: _____ Length of Pregnancy: _____

General Health of Mother:

_____

Complications:

_____

Medications taken during pregnancy:

_____

Delivery:

Duration of Labor: _____ Type of Delivery: _____

Difficulties during delivery:

_____

_____

Birth weight: _____ Birth Length: _____

Intensive Care (NICU) needed? __ Yes__ No Length of Stay: _____

Any health problems the first 2 weeks of life?

_____

_____

_____

MEDICAL HISTORY

Hospitalizations: O Yes O No Describe: _____

High Fevers: O Yes O No Describe: _____

Ear Infections: O Yes O No Describe: _____

Hearing Problems: O Yes O No Describe: _____

Vision Problems: O Yes O No Describe: _____

Allergies: O Yes O No Describe: _____

Surgeries: O Yes O No Describe: _____

Seizure Disorder: O Yes O No Describe: _____

Colic: O Yes O No Describe: _____

Is your child presently under the care of any doctor other than your pediatrician?

O Yes O No

Name of Doctor: _____

Reason: _____

Medications:

Current:

_____

Previous:

_____

MEDICAL PRECAUTIONS:

Are there any precautions the therapist should be aware of when working with your child?

_____

_____

_____

Developmental History

Motor milestones: At what age did your child:

Roll: _____ Sit: _____ Pull to stand: _____ Crawl: _____ Walk: _____

Ride a tricycle: _____ Ride a bike: _____ Use writing utensil: _____

Cut with scissors: _____ Feed self: _____ Reach for objects: _____

Drink from cup: _____ Use a Straw: _____ Toilet Training: _____

Speech/Language milestones:

Did your child babble and coo during infancy? _____

When did your child say his/her first word? _____

When did your child begin to put words together? _____

Does your child speak clearly? O Yes O No

Do others understand your child? O Yes O No

Is your child's voice hoarse or husky? O Yes O No

Describe:_____

Does your child Stutter? O Yes O No

Describe:_____

Has your child's speech/language been evaluated prior? O Yes O No

Where? _____ When? _____

Results? _____

Is your child self conscious about his/her speech? _____

Social History:

How does your child play with other children: please check all that apply:

- o Cooperative
- o Aggressive
- o Makes friends easily
- o Shares well with others
- o Leader
- o Picked on
- o Needs to be in control
- o Extremely shy

List any concerns you may have about your child's social skills:

_____

Favorite toys/activities:

_____

Behavior: Please check all that apply to your child:

- o No specific problems
- o Difficult to discipline
- o Plays well with others
- o Self injurious behavior
- o Easily frustrated
- o Short attention span
- o Easily distracted
- o Redirects with support

Educational History:

Please list schools attended (include day care and preschools):

Dates attended: Name/location/district:

_____

_____

_____

Is your child in a special education classroom and/or receiving special education services?

_____

Please describe services:

_____

_____

Therapy History:

List any therapy your child has received (When, where, and duration treatment):

_____

_____

_____

_____

Is there any other important information that you feel may be helpful to your child's treatment?

_____

_____

_____

_____

What goals would you like your child to achieve through therapy?

_____

_____

_____

This information will be kept confidential and used solely for the purpose of providing the appropriate care to your child. Thank you.