Speech-Language Pathology Services, Inc.

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Client History Form

Please complete this information and email it to SLPSwhiteville@gmail.com or mail it to the above address or fax it to the number listed above, if necessary. If you have any previous evaluations or reports that would be helpful, **please bring them to the evaluation.** If requested, please bring photographs with this information (refer to "What to Bring to the Evaluation" included in this packet). SLP Services, Inc. will return all the photos.

Client's Name: _____ Birth Date: _____ Age: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Diagnosis (if any): _____

Referred by: _____

Person Completing This Form: _____ Relationship to Client: _____

FAMILY INFORMATION

Mother's/Caregiver's Name: _____ Age: _____

RELATIONSHIP TO CHILD (please check one): ☐ Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other

Highest level of education: _____ Occupation: _____

Father's/Caregiver's Name: _____ Age: _____

RELATIONSHIP TO CHILD (please check one): ☐ Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other

Highest level of education: _____ Occupation: _____

If both primary caregivers work, who cares for the child? _____

Address: _____

Phone: _____When is the client in this childcare facility? _____

Predominant Language Spoken in the Home: _____

FAMILY HISTORY

Client lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Names and ages of brothers and sisters: _____

_____

_____

_____

Is there any history of speech, language, and/or hearing problems in other family members?

If so, please describe: _____

_____

_____

_____

Are there any family stressors that may impact the client's behavior?

NO	YES	EVENT	EXPLANATION
		Marital separations/divorce	
		Death in the family	
		Financial crisis	
		Job change/difficulties	
		School problems	
		Legal problems	
		Medical problems	
		Household move	
		Extended separation from parents	
		Other stressful event(s)	

BIRTH HISTORY (for the client being evaluated):

1. Hospital where born + city +state: _____
2. Pediatrician's Name: _____
3. Gestational Age at time of delivery (or # weeks early or late): _____
4. What were the baby's APGAR scores? 1 minute _____ 5 minutes_____
5. What was the baby's birth weight? _____ Birth length? _____
6. Type of Delivery (Vaginal/C-Section): _____

What was the condition of the infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated, etc.):

NO	YES	DESCRIPTION	EXPLANATION
		Was blue/cyanotic at birth	
		Required stimulation to breathe	

		Required oxygen at birth	How much/what type?
		Required resuscitation	
		Was considered small for gestational age	
		Had tremoring or seizures	Which/for how long?
		Very low tone	
		Brain hemorrhage	
		Anemia and/or transfusions	Which/how many times?
		Jaundice (yellow)	How much/how treated?
		Had bruising	
		Rh incompatibility problems	
		Infections	
		Congenital birth defects	
		Aspiration (meconium or fluid)	Which/how treated?
		Respiratory distress signs or syndrome	
		Needed ventilation	What type/how long?
		Choking or vomiting episodes	
		Tube feedings	
		Needed medications	

MEDICAL HISTORY

It is very important to have as complete a medical history for the client as possible. Please complete the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include the client's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

NO	YES	DESCRIPTION	EXPLANATION
		Frequent colds/respiratory illness/RSV	
		Frequent strep throat/sore throat	
		Frequent ear infections (tubes?)	
		Birth defect/genetic disorder	
		Lung condition/respiratory disorder	
		Heart condition	
		Kidney/renal disorder	
		Urinary problems/infections	
		Hormonal problem	
		Muscle disorder/muscle problem	
		Joint or bone problems	
		Skin disorder/skin problems (eczema)	
		Visual disorder/vision problems	
		Eye infections	
		Neurological disorder	
		Seizures or convulsions	
		Stomach disorder/stomach pain	
		Vomiting/digestion problems	
		Failure to gain weight/feeding problems	
		Constipation/diarrhea problems	
		Dehydration episodes	
		Does your child wake up during the night?	
		Does your child snore?	
		Does your child sleep w/their mouth open?	

		Hearing loss	
		Head injuries or concussions	
		Ingestion of toxins, poisons, foreign objects	
		Major medical procedures (detail below)	
		Chronic medications (for what? when?)	
		Any major childhood illness (pox, croup,	
		Autism	
		ADHD	
		Allergies or asthma	
If you answered yes to allergies, please list allergies, reactions, as well as severity on a scale of 1-10			

HOSPITALIZATIONS AND/OR SURGERIES: Date(s) and Reason(s)

1. _____
2. _____
3. _____
4. _____

PRESENT HEALTH STATUS: Most recent Height: _____ Weight: _____ Date: _____
Please note any illnesses for which the client is currently being treated:_____
_____

CURRENT MEDICATIONS (over the counter or prescription): _____
_____

FEEDING HISTORY:

1. Please explain, in your own words, the client's current feeding problem (if any)
   _____
   _____
   _____
   _____

2. Was the client breast fed? _____ From when to when? _____

   Was the client bottle fed? _____ From when to when? _____

Please describe the client's initial skill on the breast and/or bottle:

_____
_____
_____
_____

3. During these early feedings did the client frequently arch, cry, spit up, gag, cough, vomit, or pull off the nipple? List any behaviors you saw and describe when they would happen, why and for how long:

_____
_____

4. Describe how the weaning process from the breast and/or bottle went, and why the client was weaned:

_____
_____
_____

5. At what age did the client transition from baby cereal? _____ Baby food? _____

   Finger food? _____ Transition fully to table food? _____

   Please describe how these transitions were handled by the client, especially if any difficulties occurred:

_____
_____

6. Has the client ever been on any type of special diet (other than previously described)?_____

   If yes, please describe the type of diet, at what ages, and the client's response:

_____
_____
_____

DEVELOPMENTAL/SOCIAL HISTORY

We would like to have information about the client's developmental milestones. Indicate the age when the client first performed each of the following INDEPENDENTLY. If you cannot recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If the client has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE	GOOD/FAIR	POOR
Smiled						
Held head up						
Rolled over						
Reached for an object (actively)						
Transferred object between hands						
Sat unsupported						
Crawled						
Stood alone						
Walked by himself/herself						
Said first words						
Threw objects (actively)						
Ran by himself/herself						
Followed simple one-step directions						

Said 2-3 word phrases						
Ate unaided with a spoon/fork						
Dressed by himself/herself						
Rode bicycle without training wheels						
Caught a thrown object						
Demonstrated handedness (which?)						
Knew colors						
Counted to 5						
Knew alphabet						
Potty trained						

1. Do you feel the client was "faster" or "slower" than his/her peers in any other way? Please explain:
   _____
   _____

2. If the client is in school, please describe any difficulties or strengths in reading, writing or spelling:
   _____
   _____

3. Name of previously attended school(s): _____ grade(s): _____
   school(s): _____ grade(s): _____
   school(s): _____ grade(s): _____

4. Name of current school: _____ grade: _____
   Address: _____ Phone: _____
   Any special education services (which, when)? _____
   Teacher(s): _____

   What comments have other adults, e.g., teachers, made about the client's speech and language?
   _____
   _____
   _____

5. How does the client relate to peers?
   _____
   _____
   _____
   _____

6. Compared to other children of similar age, how would you describe the client's overall behavior and ability to listen and follow directions?
   _____
   _____
   _____

7. Has the client had problems with any of the following (beyond expected for child's age):

DESCRIPTION	NO	YES	EXPLANATION
Sleeping problems			
Bed wetting			
Drooling			
Thumb sucking			
Temper tantrums			
Head banging			
Breath holding			
Aggression/destructiveness			
Nervous habits (nail biting, etc.)			
Major mood swings			
Under or overreactive to sounds			
Under or overreactive to clothing			
Under or overreactive to taste			
Under or overreactive to smell			
Any unusual fears (please describe)			

PRIVATE THERAPY OR SCHOOL THERAPY

Agency: _____

Therapist's Name: _____

Type of Therapy (Speech, OT, PT, Vision, Mental Health):

_____

_____

_____

CONCERNS

In your own words, please describe your concerns about the client regarding feeding, speech, and language abilities:

_____

_____

_____

_____

_____

What other evaluations have been completed and what were the results, or what were you told?

_____

_____

_____

_____

_____

What treatments have been tried for this problem, and what were the results?

_____

_____

_____

_____

PHYSICIANS

Pediatrician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Other Physicians:

1. _____
2. _____
3. _____

Please list any other individuals you would like to receive a copy of the evaluation report.
Name, Address, and Fax Number:

1. _____
2. _____
3. _____

IF YOU HAVE CONCERNS ABOUT THE CLIENT'S FEEDING / SWALLOWING DEVELOPMENT, PLEASE COMPLETE THE FOLLOWING. IF NOT, PLEASE GO TO PAGE 9, ANSWER THE LAST QUESTION, AND SIGN.

IF THE CLIENT EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

List the foods the client will currently eat and drink (put a star beside his/her favorites):

_____
_____
_____
_____

List any foods/drinks the client refuses:

_____
_____
_____
_____

Indicate with a check mark any aversions/problems or preferences the client may have.

	LIKES	DISLIKES	REFUSES	DIFFICULTY MANAGING
Thin liquids (water, juice)				
Thick liquids (milkshakes)				
Purees (pudding)				
Textured puree (apple sauce)				
Mixed texture (cereal with milk)				
Soft solids (banana, cheese)				

Crunchy solid (Cheeto, cracker)				
Chewy solid (meat)				
Cold foods				
Room temperature foods				
Warm foods				

Does the client have food preferences based on color, shape, or flavor (sweet, salty, sour)? If yes, please explain:

_____
_____
_____
_____

Does the client have any other feeding preference or aversions not mentioned above? If yes, please explain:

_____
_____
_____

IF THE CLIENT IS TUBE FED, PLEASE ANSWER THE FOLLOWING QUESTIONS:

What type of formula is used and how is it mixed (pre-blended, blender)?

_____
_____

Please provide details of the client's feeding schedule below:

Time of Feeding (start time)	NG, G or J Tube	Amount	Gravity or Pump	Over What Time Period/At What Rate

Describe where the client is tube fed and what activities are occurring at the same time:

_____
_____

Describe the client's reactions to the tube feedings (connecting, during, disconnecting):

_____
_____

If there is anything else you feel would help us to better prepare for the evaluation, please describe:

_____
_____
_____

_____ _____

Signature of Parent/Legal Guardian Date