

# YOUR LETTERHEAD

## CLIENT INFORMATION FORM ***THIS INFORMATION IS CONFIDENTIAL***

To New Clients:

Please answer each question as fully as possible. The information requested is strictly confidential, and is used only for the purpose of designing an appropriate educational program to meet new clients' individual needs. If you have any questions regarding this questionnaire, please let me know. Thank you for your assistance.

**DATE:** \_\_\_\_\_ **REFERRAL SOURCE:** \_\_\_\_\_

### 1. BACKGROUND

**NAME OF CLIENT** \_\_\_\_\_ **NICKNAME** \_\_\_\_\_  
Last First Middle

**ADDRESS** \_\_\_\_\_  
\_\_\_\_\_

**PHONE** \_\_\_\_\_

**AGE** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_ **SCHOOL GRADE** \_\_\_\_\_  
Yrs. mo. Mo. day year

Is Client adopted? \_\_\_\_\_ At what age? \_\_\_\_\_

Client's principal residence is with: Two parents/guardians/caretakers \_\_\_\_\_;  
Mother \_\_\_\_\_; Father \_\_\_\_\_; Other (Specify) \_\_\_\_\_

### FAMILY INFORMATION

	Caretaker #1	Caretaker #2
NAME		
ADDRESS		
PHONE: CELL	( )	( )
PHONE: HOME	( )	( )
BIRTHDATE		
OCCUPATION		
EMPLOYER		
EDUCATION (HIGHEST LEVEL COMPLETED)		

**PARENTS' MARITAL STATUS:** Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Remarried \_\_\_\_

If remarried, which parent? \_\_\_\_\_

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**LIST SIBLINGS IN ORDER OF BIRTH**

NAME	AGE	SCHOOL GRADE	RELATIONSHIP TO CLIENT

Other members of this household? \_\_\_\_\_

**Please list any agencies, psychologists, speech pathologists, tutors, or educational therapists who have evaluated and/or provided treatment for this client.**

NAME	PROFESSION	DATES OF TREATMENT

**2. SCHOOL HISTORY**

LIST ALL SCHOOLS ATTENDED:

Preschool \_\_\_\_\_

Elementary \_\_\_\_\_

Middle School \_\_\_\_\_

High School \_\_\_\_\_

School currently attended \_\_\_\_\_

Address \_\_\_\_\_

Teacher name \_\_\_\_\_

Has this client ever repeated a grade? \_\_\_\_\_ If so, explain \_\_\_\_\_

Has this client received special services in school, such as resource or special day classes? Please list:

\_\_\_\_\_

\_\_\_\_\_

Age at which you started to suspect learning problems \_\_\_\_\_

Age at which school related problems were identified \_\_\_\_\_

Has the school indicated that client is below grade level in reading or other academic subjects? If yes, give estimated grade level \_\_\_\_\_

What is the client's general feeling about school? Do they see themselves as a problem learner?

\_\_\_\_\_

\_\_\_\_\_

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## 3. SPEECH AND LANGUAGE INFORMATION

Primary language spoken at home \_\_\_\_\_

Other languages spoken? \_\_\_\_\_

If English is not the primary language, when did client learn English? \_\_\_\_\_

As a child, what adults did client have to talk with, especially adults who had time to listen and have a conversation with client? List adults, and relationship to client. \_\_\_\_\_

Did any of the available adults have a speech impairment? Please describe any possible effects on client. \_\_\_\_\_

During the first six months of life, did the client babble and coo? \_\_\_\_\_

As a child, did client ask for names of things? \_\_\_\_\_

Does client now forget or have problems saying the exact name of common objects? \_\_\_\_\_

As a child, did client ask for the meanings of unknown words? \_\_\_\_\_

At what age was client's speech clear and easy for non-family members to understand? \_\_\_\_\_

If client has problems with clarity of speech, please explain \_\_\_\_\_

How many times a week did you or other adults read to client (when a child) \_\_\_\_\_

Did (or does) client request adults to read aloud:

Regularly \_\_\_\_\_ Infrequently \_\_\_\_\_ Never \_\_\_\_\_

Does client pick up books and read voluntarily:

Regularly \_\_\_\_\_ Infrequently \_\_\_\_\_ Never \_\_\_\_\_

At what age as a child did client ask to write their name and other words? \_\_\_\_\_

Does client speak more than, less than, or about as much as siblings? \_\_\_\_\_

How well does client express strong feelings in words? \_\_\_\_\_

## 4. MEDICAL HISTORY

### A. PRENATAL/NEONATAL HISTORY

If client was adopted, at what age did child enter your home? \_\_\_\_\_

Was child ever in foster care? If so, indicate length of stay and age at leaving \_\_\_\_\_

### B. PREGNANCY HISTORY

Length of pregnancy (40 weeks = full term) \_\_\_\_\_

Medications used \_\_\_\_\_

Serious illness/accidents during pregnancy \_\_\_\_\_

Use of narcotic drugs? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Smoking? \_\_\_\_\_

Pregnancy was: Easy \_\_\_\_\_ Average \_\_\_\_\_ Difficult \_\_\_\_\_

### C. BIRTH

Duration of labor \_\_\_\_\_ Birth weight \_\_\_\_\_

Type of delivery \_\_\_\_\_ Birth injuries? \_\_\_\_\_

Seizures? \_\_\_\_\_ Infections? \_\_\_\_\_

Breathing difficulties? \_\_\_\_\_ Feeding difficulties? \_\_\_\_\_

Jaundice or anoxia? \_\_\_\_\_ Other? \_\_\_\_\_

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## D. CHILDHOOD

During the first months of life, was this child:

Extremely active and strong? \_\_\_\_\_ Normally active? \_\_\_\_\_ Sluggish and weak? \_\_\_\_\_

During the first months of life, was this child:

Highly attentive to sights and sounds? \_\_\_\_\_

Moderately attentive to sights and sounds? \_\_\_\_\_

Unresponsive to sights and sounds? \_\_\_\_\_

**Please check any of the following conditions your child had, and age at which it occurred:**

\_\_\_\_\_ Multiple ear infections (before age 5) \_\_\_\_\_

\_\_\_\_\_ Meningitis/Encephalitis \_\_\_\_\_

\_\_\_\_\_ Serious infection (specify) \_\_\_\_\_

\_\_\_\_\_ Head injury (with concussion, loss of consciousness) \_\_\_\_\_

\_\_\_\_\_ Chronic headaches or migraines \_\_\_\_\_

\_\_\_\_\_ Seizures \_\_\_\_\_

\_\_\_\_\_ Allergies (list type and treatment) \_\_\_\_\_

**List childhood illnesses/hospitalizations. Give age, type, and severity/complications.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date of last hearing check?** \_\_\_\_\_ **Checked by?** \_\_\_\_\_

**Date of last vision check?** \_\_\_\_\_ **Checked by?** \_\_\_\_\_

Wears glasses? \_\_\_\_\_ Specify when glasses are required \_\_\_\_\_

Was client ever on medication for more than a month, for any illnesses or problems, including ear infections or seizures? (Specify) \_\_\_\_\_

**Current medications?** \_\_\_\_\_

Supervised by? \_\_\_\_\_

**Has client had any of the following? If so, check and state results, if known:**

\_\_\_\_\_ Electroencephalogram (EEG) \_\_\_\_\_

\_\_\_\_\_ Computerized Tomography (CT scan) \_\_\_\_\_

\_\_\_\_\_ Head X-rays \_\_\_\_\_

\_\_\_\_\_ Blood chemistries \_\_\_\_\_

## 5. DEVELOPMENTAL HISTORY

Was this an easy or difficult baby to care for? \_\_\_\_\_

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Did development overall seem slow, average, or advanced? \_\_\_\_\_

**Check any areas of concern:**

- \_\_\_\_\_ Gross motor (Large body skills, running, balancing, etc.)
- \_\_\_\_\_ Fine motor (Hand and manipulative skills, drawing, cutting, etc.)
- \_\_\_\_\_ Social skills (Making and keeping friends, sharing, etc.)
- \_\_\_\_\_ Adaptive skills (Feeding, dressing, bathroom skills, etc.)
- \_\_\_\_\_ Language (Speaking, understanding instructions, clarity of speech, etc.)

**Milestones:** State age when these skills emerged

- \_\_\_\_\_ Turned over; \_\_\_\_\_ Sat alone; \_\_\_\_\_ Walked alone; \_\_\_\_\_ Crawled; \_\_\_\_\_ Fed self;
- \_\_\_\_\_ First words; \_\_\_\_\_ Toilet trained; \_\_\_\_\_ Slept through night;
- \_\_\_\_\_ Preferred use of one hand (which?); \_\_\_\_\_ Full sentences

**Did (or does) client experience:**

- \_\_\_\_\_ Feeding problems; \_\_\_\_\_ Sleep problems; \_\_\_\_\_ Colic; \_\_\_\_\_ Rocking/head banging;
- \_\_\_\_\_ Breath holding; \_\_\_\_\_ Severe temper tantrums; \_\_\_\_\_ Stuttering; \_\_\_\_\_ Constipation;
- \_\_\_\_\_ Tics or nervous twitches; \_\_\_\_\_ Stomach aches

**Can client:**

- \_\_\_\_\_ Ride a bicycle; \_\_\_\_\_ Jump rope; \_\_\_\_\_ Skate; \_\_\_\_\_ Skip; \_\_\_\_\_ Swim;
- \_\_\_\_\_ Throw and catch a ball

**Hobbies:** \_\_\_\_\_  
 \_\_\_\_\_

**What activities is client encouraged to pursue:**

- \_\_\_\_\_ musical; \_\_\_\_\_ religious; \_\_\_\_\_ academic; \_\_\_\_\_ sports; \_\_\_\_\_ artistic; \_\_\_\_\_ mechanical;
- \_\_\_\_\_ other: \_\_\_\_\_

**In what activities has client been particularly successful and/or interested?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**OUT-OF-SCHOOL ACTIVITIES:**

EXPERIENCES	VERY OFTEN	OCCASIONALLY	INFREQUENTLY
Music lessons			
Religious training			
Family hobbies			
Day camp			
EXPERIENCES, continued	VERY OFTEN	OCCASIONALLY	INFREQUENTLY
Resident camp			
Vacation travel			

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Camping			
Museums			
Neighborhood play			
Organized sports			
Swim or dance class			
Reading (independently)			
Theater, Movies			
Computer or other electronic games			
Computer based activities (Internet, etc.)			
TV (note hours per day)			

### 6. BEHAVIOR

Cross out those behaviors that do not apply to client. Check the box that indicates how frequently the behavior occurs.

BEHAVIOR	USUALLY	OFTEN	SELDOM	NEVER
Cheerful				
Confident				
Fidgety, restless				
Argumentative				
Shy, withdrawn				
Easily frustrated				
Very active physically				
Very talkative				
Bed wets				
Awkward, clumsy				
Difficulty in concentration				
Defiant				
Leaves projects uncompleted				
Sleeps poorly				
Eats little				
Short attention span				
Forgets easily				
Loses possessions				
<b>BEHAVIOR, continued</b>	<b>USUALLY</b>	<b>OFTEN</b>	<b>SELDOM</b>	<b>NEVER</b>
Resents or forgets chores				
Resents or forgets homework				

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Plays well with others				
Expresses self well verbally				
Fearful				
Poor sense of time/direction				
Generally optimistic about self				

**Please comment on any significant academic, physical, or social difficulties that client has experienced:**

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### 7. GUIDANCE ISSUES

Client is: \_\_\_\_\_ easily managed; \_\_\_\_\_ fairly easily managed' \_\_\_\_\_ difficult to manage

Client is sensitive to approval and disapproval: \_\_\_\_\_ extremely; \_\_\_\_\_ average; \_\_\_\_\_ rarely

Methods of guidance used in family:

By Parent/Caretaker # 1 \_\_\_\_\_

By Parent/Caretaker # 2 \_\_\_\_\_

Are there differences of opinion in your family or household about behavior management of client?

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For what behaviors do you have to discipline? \_\_\_\_\_

Client's reaction to methods of discipline? \_\_\_\_\_

Which methods work best? \_\_\_\_\_

Do any of those who supervise this client have more difficulty/ success than others? Describe fully:

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What present behavior is most difficult for you to cope with? \_\_\_\_\_

What present behavior do you hope to change? \_\_\_\_\_

**What do you value most about this client?** \_\_\_\_\_

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**What words would this client use to describe themselves?** \_\_\_\_\_

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## 8. FAMILY MEDICAL HISTORY

List family members and relatives with:

CONDITION	RELATION TO CLIENT
Reading problems (dyslexia)	
Speech problems or late speaking	
Hearing problems	
Learning difficulties	
Math problems	
Writing problems	
Hyperactivity	

Have any of the above problems had any effect on client? Specify: \_\_\_\_\_

Do any of the following medical or genetic conditions run in the family?

\_\_\_\_ Migraine

\_\_\_\_ Seizures or convulsions

\_\_\_\_ Neurological disorders

\_\_\_\_ Depression

\_\_\_\_ Other psychiatric conditions (specify) \_\_\_\_\_

**Please add any comments here that would help us further understand this client:**

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