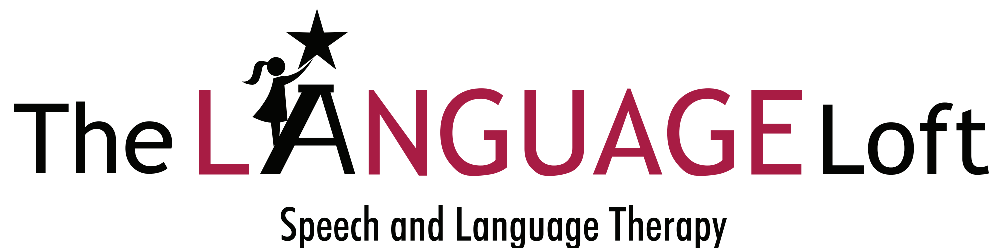

NEW CLIENT INFORMATION FORM

Client's Name: ____ Date: ____________

Date of Birth: ______________ Age: ________ Primary Language: ____________________

Secondary Language: _________________

Address: ____

School: ________________________________ Grade: _________

Parent's Name: _______________________________ Phone #: ______________________

Email: ____

Occupation: ____

Parent's Name: _______________________________ Phone #: ______________________

Email: ____

Occupation: ____

Emergency Contact: _________________________________ Phone #: _________________

Are both parents living in the home? ___________________

Siblings and/or other family members living in the home (names and ages): __________________

____

Pediatrician: __________________________________ Phone #: ______________________

REASON FOR REFERRAL:

What are your concerns? ____

____

____

How does your child typically communicate (e.g. gestures, single words, short phrases, complete sentences, etc.)?

____

____

Has your child previously received speech therapy, occupational therapy, or any other services? If so, please indicate the name of the specialist and when your child was seen.

____

____

Is there a family history of speech, language, hearing, or learning concerns?

____

____

BIRTH HISTORY:

Length of Pregnancy: ________________ Mother's age at birth of child: ____________________

Mother's general health during the pregnancy (illnesses, accidents, medications, etc.):

____

____

Length of Hospital Stay: Mother: ____________________ Child: _____________________________

Explain any complications after birth of child:

____

____

MEDICAL HISTORY:

What diagnoses, if any, have been made by a specialist or physician?

____

____

Describe any accidents, surgeries, or hospitalizations:

____

____

Is your child currently taking any medications? ____

____

Allergies: ____

Has your child had any of the following? (Please circle)

Seizures   Ear Infections   High Fevers   Asthma   Allergies

Please Explain:

____

____

Date and results of most recent hearing test or screening:

____

SOCIAL / BEHAVIOR:

Please circle any of the following that apply to your child:

Bedwetting	Sleeping Problems	Separation Difficulties (From Parent)
Temper Tantrums	Eating Problems	Unusual Physical Movement
Hand Flapping	Head Banging	Bites Self / Objects / Others
Toe Walking	Tics / Nervous Habits	Unreasonable Fears or Worries
Staring Spells	Repetition of Activities	Trouble Getting Along with Others
Hurts Self on Purpose	Short Attention Span	Difficulty with Change (Activities / People)
Preoccupation with Certain Objects		

SENSORY / MOTOR:

Please circle any of the following that apply to your child:

Touch:	Hearing:	Vision:
Fearful of Having Face Washed	Overly Sensitive to Sounds	Overly Sensitive to Bright Light
Does Not Like to be Touched	Unable to Hear Whispers	Squints Eyes
Tries to Touch Everything / Everyone	Speaks Loudly	Tilts Head to Look at Things
Insists on Holding Object in Hand	Ignores Sounds / Noises	
Does Not Respond to Pain		

Movement / Coordination:	Taste / Smell:
Rocks Body	Mouths Objects
Seeks Rough Play	Avoids Certain Textures of Food
Likes Fast Moving / Spinning Activities	Overly Sensitive to Smell
Is Hesitant at Stairs / Curbs	Drools
Bumps into Things / Accident Prone	Difficulty Chewing / Swallowing
Fearful When Feet are off the Ground	Eats Only Soft Food

DEVELOPMENTAL HISTORY:

Describe any problems during infancy (difficulty with sucking, swallowing, eating solid foods, sleeping, irritability, etc.):

____

____

Approximate age at which your child began the following activities:

Crawl: ________________ Sit: ________________ Stand: ________________

Walk: ________________ Feed Self: ________________ Dress Self: ________________

Use Toilet: _______________ Use Single Words (no, mom, puppy, etc.): ____________________

Combine Words into Phrases (me go, baby shoe, etc.): ____________________________________

Name Objects (book, milk, ball, etc.): ____

Use Simple Sentences (where's mommy? I go play, etc.): __________________________________

Engage in Conversation: ____

EDUCATIONAL HISTORY:

How is your child doing academically? ____

____

____

How does your child interact with others (shy, aggressive, uncooperative, etc.)?

____

____

Does your child receive special education services and/or have an Individualized Education Plan (IEP)? If so, please provide a brief description of his/her goals or attach a copy of the IEP.

____

____

Please provide any additional information that may be helpful for your child's evaluation or treatment.

____

____

____

____

Person completing this form: ____

Relationship to child: ____

How were you referred to The Language Loft? ________________________________

Signed: _______________________________________ Date: _______________