



## Client Background Information

Today's Date \_\_\_\_\_

Name of person completing form (relationship to client);  
\_\_\_\_\_

Referred by (e.g. parent/doctor) \_\_\_\_\_

Child's Name \_\_\_\_\_ M F DOB \_\_\_\_\_ Age \_\_\_\_\_

Child's Full Address \_\_\_\_\_

Name of Parent(s)/Guardian(s) Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email address \_\_\_\_\_

Alternate Address \_\_\_\_\_

Please list other children in family (including age) \_\_\_\_\_

Reason for referral \_\_\_\_\_

Has the child been seen by a Speech-Language Pathologist? Yes No

If yes, date \_\_\_\_\_

Name of SLP and Facility \_\_\_\_\_

If yes, findings \_\_\_\_\_

Has the child been seen by any other professionals? Yes No

If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

### Speech and Language History:

What is your child's first language? \_\_\_\_\_ Second language? \_\_\_\_\_



When did your child say his/her first words? \_\_\_\_\_

When did your child combine words to form sentences? \_\_\_\_\_

How does your child typically communicate (i.e. with gestures or words)?

Give an example of something your child communicated today (either with words or gestures).

Is this typical. If not, how many words does your child put together to form a sentence?

Does your child understand:

a) single directions (e.g. point to your nose) Yes  No

b) 2 step directions (e.g. get your shoes and give them to me) Yes  No

c) simple questions (e.g. where's your teddy?) Yes  No

How well do you understand your child (from 0% to 100%)? \_\_\_\_\_; Other family members? \_\_\_\_\_

How well do strangers understand your child (from 0% to 100%)? \_\_\_\_\_

Are there certain sounds that you child has difficulty pronouncing?

Yes  No  If yes, provide examples \_\_\_\_\_

What does your child do if she/he is not understood? \_\_\_\_\_

Does your child stutter? (e.g. gets stuck, repeats sounds/words)

Yes  No  If yes, describe \_\_\_\_\_

**Hearing:**

Has your child had ear infections? (If yes, how many?) \_\_\_\_\_

Does the child seem to have any difficulty hearing? Yes  No

Has your child had a hearing test? Yes  No

If yes, what were the results and recommendations?



**Social/Play History:**

Does your child enjoy or avoid the company of other children? \_\_\_\_\_

What are your child's favorite interests? \_\_\_\_\_

Does your child make eye contact with you when speaking or interacting? \_\_\_\_\_

**Prenatal and Birth History:**

Please describe any complications during pregnancy or birth \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please indicate any illnesses which the child has had, such as high fevers, measles, tonsillitis, earaches, etc.

\_\_\_\_\_

Does your child have any allergies? Yes  No

If yes, please describe \_\_\_\_\_

At what age did your child crawl? \_\_\_\_\_ walk? \_\_\_\_\_

Does your child drool? \_\_\_\_\_

Do you have any concerns about your child's eating? \_\_\_\_\_

**Education:**

Does your child currently attend school? Yes  No

If yes, list school and grade \_\_\_\_\_

**Insurance Coverage:**

Navigating your benefits can be a confusing process. Achieve can help you support you in accessing insurance coverage (e.g., do I need a doctor referral, what is the coverage available, how many sessions, etc.). If you would like support in this area, please provide your insurance company name and plan level.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**All information on this document is confidential.**