Fischer Speech Therapy Solutions

Client History Form

Client name: _____ Date of Birth: _____

Parent's names: _____

Sibling's names and ages: _____

Was your child carried to full term? Y N
If no, how many weeks gestation? _____
Was your child delivered via C-section? Y N
Did he/she pass the newborn hearing screening? Y N
Birth History/complications (if any):

_____
_____
_____
_____
_____

Please describe any hospitalizations, illnesses, or major concerns that are important to know about your child.

_____
_____
_____

Please list all medications your child is taking.

_____
_____

Please state the age when your child began
Crawling: _____ Walking:_____ Talking: _____

Does your child self-feed? Y N

Does he/she have any food aversions? Y N,
If yes, please describe:
_____

Please list your concerns regarding your child's ability to communicate.
_____
_____
_____
_____

Do strangers have a difficult time understanding your child? Y N
Does your child become easily frustrated when not understood? Y N
Does your child have difficulty hearing? Y N
Has your child ever had tubes in his/her ears? Y N
Has your child's hearing been tested by an ENT? Y N
Does your child have difficulty understanding and following directions? Y N
Does your child have difficulty formulating meaningful sentences or getting his/her point across? Y N
Do you feel your child has an adequate vocabulary for his/her age? Y N
Is your child able to answer different types of questions (how, why, where, when)? Y N
Please describe any academic difficulties your child faces in a classroom setting.
_____
_____
_____
_____

Do you feel your child has a stuttering problem? Y N
If yes, please describe your concerns:
_____
_____
_____