Hamaguchi & Associates
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Patient History Form
(New Client: Birth-5 Years)

Please complete and return this form at least 7 days before your child's first scheduled appointment, along with the following, if applicable: physician's referral, previous evaluation reports from other educational, audiological, psychological or speech professionals. If you have one available, it is helpful to include a current picture of your child.

1. Contact/Insurance Information

Child's Legal First Name: ____
Nickname:____________________
Child's Last Name: ____
Date of Birth: ____________________ Age: ____________ Male____ Female____

Address____
City/Zip____
Home Phone_____________________________________

Mother's/Guardian's/Partner's Name____
Occupation________________________________Employer____________________
Email: ____ Cell:__________________

Father's/Guardian's/Partner's Name____
Occupation________________________________ Employer____________________
Email: _____________________________________ Cell:_____________________

How did you hear about our practice? ______________________________________

Do you intend to seek insurance reimbursement? ❑Yes ❑No

If you checked "yes," please read a copy of our information sheet, "If You Intend to Seek Insurance Reimbursement". We would like to send your physician a copy of any reports pertaining to your child's care. Please sign below to give us permission to do so.

Name/Address of Child's Primary Physician who will be referring for services:
____
Name of Insurance Company____
Policy Holder________________________ Policy Number_____________________________

I give permission for Hamaguchi & Associates to provide information to my insurance company and referring physician as requested for the purpose of reimbursement:

Parent Signature____ **Date**__________

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2. Family Information

Parents/Guardians/Partners are:

- ❑ Solo/single parent
- ❑ Legally married
- ❑ Living apart (If so, who is the primary legal custodian?)____
- ❑ Living together

Name and age of child's siblings____

____

Does anyone else live with you? ____

Do you have any pets? Please tell us about them.

____

3. Child's Birth History

❑ Biological child ❑ Adopted ❑ Presently a foster child

For adopted/foster children:

If adopted or foster child, at what age the did the child join family? _________________

If available, please describe the care/history of your child prior to joining your family (e.g. in orphanage from birth, taken from natural parents at age 3, in 5 foster homes since 18 months, etc.) Pre-placement information: ___________

____

____

At the time the child was placed with you, were there developmental delays or health/behavioral issues? Please explain:____

____

Pregnancy and Birth

Any complications or time spent in the NICU?

____

____

Weight at birth (if known)? __________________

4. Language History

For children learning more than one language:

What languages has your child been raised to speak by his/her primary caregiver(s) and parents?

____

At what age was your child introduced to English on a regular basis? _______

What settings is your child currently spoken to in English (in percentages)?

home ______ % school ________%

What language do you feel is your child's strongest language? ___________________

Do you find that your child is weak/behind in both languages? ❑Yes ❑No

**Please note that if your child's strongest language is a language other than English or is fairly equal (bilingual) we will need to do a bilingual assessment if there are any issues or concerns, other than simple pronunciation difficulties.

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By comparing language and listening skills in both languages, we can better determine if the difficulty is pervasive (a true disorder) or simply a weakness in learning English. This is important for us to know in developing a treatment plan, but also for assigning the appropriate diagnostic codes. Currently, we are only able to offer bilingual assessments in Mandarin/English. Due to the amount of time it takes to administer, score and transcribe the additional testing, these assessments are higher in fees. Please discuss this with our office staff or Director of Clinical Services at the initial intake session.

5. Which areas are of a concern to you about your child?

- ❑ pronunciation
- ❑ doesn't say real words yet
- ❑ talks very little
- ❑ mouth muscles/drooling
- ❑ chewing/swallowing
- ❑ sentence structure-words are mixed up
- ❑ grammar is poor ("Him mad!")
- ❑ uses words but not many phrases or sentences
- ❑ doesn't learn or remember new words easily
- ❑ doesn't look at people when they are talking to him/her
- ❑ is/was having a hard time in preschool with: (Please tell us more)

  ____
  ____
  ____

- ❑ doesn't play with toys like other children
- ❑ doesn't "show me" things ("Look, Mom!")
- ❑ doesn't call "Mommy/Ma" to get my attention
- ❑ gets frustrated when not understood or able to express himself/herself
- ❑ is very self-directed and independent
- ❑ doesn't follow directions well
- ❑ doesn't greet people or say bye unless pushed
- ❑ doesn't respond to questions correctly
- ❑ doesn't ask questions
- ❑ talks in jargon—speech doesn't make sense
- ❑ doesn't respond to yes/no questions with head nod or shake

6. Social interaction and behavior (check all that apply)

- ❑ Typical for age
- ❑ Quiet
- ❑ Outgoing
- ❑ Tends to prefer playing alone
- ❑ Prefers to play with younger children
- ❑ Tends to say/do socially inappropriate things for a child his age; seems immature
- ❑ Is unusually active for his/her age
- ❑ Has a shorter attention span than you expect for his/her age
- ❑ Is disinterested in other children
- ❑ Unusually irritable or uncomfortable in noisy or crowded places such as malls, parties
- ❑ Very "self-directed"; has own agenda
- ❑ Often repeats phrases heard out of context
- ❑ Doesn't respond to his/her name consistently

Does your child like to be read to (mark all that apply)**?**

- ❑ Yes
- ❑ Can point to object on page when requested
- ❑ Prefers letters, objects, and numbers
- ❑ Will listen to stories with characters
- ❑ None of the above
- ❑ Prefers to look at books by his/her self and flips pages quickly

Does your child have any strong interests (e.g. trains, maps, dinosaurs, hand-washing, Pokemon), **repetitive movements, tics** (e.g. blinking, sniffing, head movements, etc.) **or behaviors** (e.g. licking hands, chewing on shirt, etc)**?**

- ❑ Yes Please list or describe: ______________________________________
- ❑ No

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Sometimes will:

- ❑ Bite
- ❑ Hit
- ❑ Scratch
- ❑ Kick other adults or children if unhappy

If yes, under what conditions (where/when/with whom) do you see these behaviors?

____

Are there any other issues regarding behavior? ____

____

7. About Your Child

Does your child seem aware of his/her speech difficulty? Is he/she frustrated at all?

____

Is there a history in the family of speech, language or learning disabilities of any kind, including hyperactivity or Attention Deficit Disorder? ____

____

Has your child previously been diagnosed with a particular condition that would affect his or her speech, language or auditory skills? (such as Down Syndrome, Autism, PDD, Cerebral Palsy, Hearing Impairment, etc)

❑ Yes Please explain: ____

❑ No

What are your child's favorite activities, games, toys and books?

____

____

What upsets your child? ____

____

When your child is upset, what are some ways he/she is able to be calmed down? (e.g. hugs, deep pressure, calm music, etc.)

____

Tell us about your child's personality.____

____

Please summarize your primary reason for bringing your child to us for an evaluation or therapy (i.e. specific concerns and goals).We also ask that you include a separate letter telling us about your child if you have not already done so. If coming for an assessment, is there a condition or disorder you are looking to rule in or rule out? ___________________

____

____

____

Sometimes we use videos or apps during our therapy sessions for a very limited time. Are you comfortable having your child use screens/electronic devices during therapy?

____

8. Developmental Milestones

Does your child walk independently?

- ❑ Yes If so, when? _____________
- ❑ No

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Has your child begun to use any real words?

- ❑ Yes If yes, **when** do you recall the first real word was spoken? (at what age?) ____________________
- ❑ No

Does your child babble/jargon with "make believe" language like they are trying to talk?
Tell us about how your child makes noises (e.g. what kind of noises/sounds, when). Is it frequently, throughout the day or just once in a while? ____

Did your child develop language/words and then lose them?

- ❑ Yes When did you notice your child's language loss? ____________
- ❑ No

Please take a moment and write down a sample of words, phrases or sentences your child might say in a typical day.
____
____
____

At what age did you first become concerned about your child's speech-language development and why? ___________
____
____

Is your child toilet trained?

❑ Yes Age? _______   ❑ No

9. Health History

Is your child presently taking any prescription medication?

- ❑ Yes Please tell what it is and why it is taken: ____
- ❑ No

Does your child take any vitamins, supplements, or non-prescription medication?

- ❑ Yes Please tell what it is and why it is taken: ____
- ❑ No

Any major illnesses or surgery to date?

- ❑ Yes Please explain: ____
- ❑ No

Any history of seizures?

- ❑ Yes Please explain what happened and at what age:________________________
- ❑ No

History of ear infections?

- ❑ Yes How frequent? Ventilation tubes? _____________________________
- ❑ No

Known vision problems? ____

Allergies? ____

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Do you have concerns about your child having anxiety? ________________________________

10. Previous Evaluations and Therapy

Please fill out an "Exchange of Information" form for us to communicate with other professionals regarding your child's assessment or therapy program, if you so desire

Has your child been evaluated or treated for a speech problem in the past?
______* Yes (If yes, please fill in dates and by whom). _____No

Date:___________________ By Whom:_____________________

Date:___________________ By Whom:_____________________

*****If yes, please make sure we receive any previous reports.***

Is your child currently receiving speech therapy at another practice, with another agency, or school?
❑ Yes ❑ No

If yes, please explain why you are seeking to change or add a new speech pathologist to your child's program:
____
____

Has your child been evaluated or treated by a physical or occupational therapist?
❑ Yes (Please fill in date and by whom below) ❑ No
Date:___________________ By Whom:_____________________
Diagnosis: ____

Is your child still currently receiving occupational therapy?
❑ Yes By Whom:__________________________ ❑ No

How often does your child receive OT and what is he/she working on? (e.g. sensory regulation, fine-motor, etc.)
____

Has your child been evaluated by a psychologist, educational therapist, or learning consultant?
❑ Yes (Please fill in date and by whom below) ❑ No
Date:___________________ By Whom:_____________________
Diagnosis: ____

Has your child been evaluated by a neurologist?
❑ Yes (Please fill in date and by whom below) ❑ No
Date:___________________ By Whom:_____________________
Diagnosis: ____

Has your child had a thorough hearing evaluation?
❑ Yes (Please fill in date and by whom below) ❑ No
Date:___________________ By Whom:_____________________
Diagnosis: ____

Has your child been evaluated by a BCBA (behavioral specialist)?
❑ Yes (Please fill in date and by whom below) ❑ No
Date:___________________ By Whom:_____________________
Is your child currently receiving ABA services? And if so who is the ABA provider? How many hours (locaton—home/school?) ____

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____

If your child is receiving ABA therapy, how is your child responding to therapy? Has it been helpful? What kinds of activities are being done during ABA? Do you have any concerns regarding your child's program?

____
____
____

What services has your child received privately? (Check all that apply)

- ❑ Tomatis/Listening Therapy/AIT
  When? __________
  Was it helpful? ________________
- ❑ Social/Pragmatic/Play Group
  When? __________
  Was it helpful? _______________
- ❑ Other: ____

11. Oral-Motor/Diet & Nutrition

Do you have any concerns about your child's chewing/eating skills?

____

Do you feel your child is a picky eater, such as eating only cold foods, yellow foods, soft/white foods, etc.?

____

Is your child on a restricted diet?

- ❑ Yes
- ❑ No
- ❑ Previously, no longer

If yes, which kind?

- ❑ Gluten-free/casein-free
- ❑ Dairy free
- ❑ Vegetarian
- ❑ Vegan
- ❑ Diabetic/sugar-free
- ❑ Other (please indicate)_____________________

How long has your child been on a restricted diet? ______________________________

What is the purpose of the restricted diet? (e.g. to improve focus/attention, due to allergies, cultural reasons, improve symptoms of autism)____

If your child was previously on a restricted diet, please tell more about your child's experience. (What kind of diet, for how long, did you notice any changes, etc.) ____
____

Please list the foods your child will typically eat and how it is prepared (e.g. cooked, chopped up, etc):

____

Has your child ever had his/her tongue tie clipped or has a dentist mentioned this (or a lip tie) to be a potential issue to monitor?

____

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Does your child feed himself/herself with a spoon and fork?
- ❑ Yes
- ❑ No
- ❑ Still learning

Does your child suck his/her thumb?
- ❑ Never did
- ❑ Yes, still does
- ❑ Used to, but has stopped

If so, about what age did your child stop? __________

Does your child use a pacifier?
- ❑ Never did
- ❑ Yes, still does
- ❑ Used to, but has stopped

If so, about what age did your child stop? __________

Was your child:
- ❑ Breast fed
- ❑ Bottle fed
- ❑ Both

If breast fed, did your child have difficulty latching? _____ yes _____ no
____

Is your child weaned from the bottle/breast?
- ❑ Yes
- ❑ No

If so, about what age was your child weaned?
Bottle? ___________ Breast? ____________

12. Education/Childcare

Does your child have an IEP or IFSP from the public schools?
- ❑ Yes If yes, what services is your child receiving? ____
- ❑ No

Has your child ever attended a preschool/kindergarten program?
- ❑ Yes
- ❑ No

Please tell about your child's preschool/kindergarten experiences, including if he/she was asked to leave a school due to behavior problems, what about the program you liked, what was not working for your child, and whether or not your child is in a program now. (Name of school(s), how many days/hours per week/ at what age did the child attend/how long) ____
____
____

Is your child currently in daycare for any part of the week ?
- ❑ Yes
- ❑ No

Please describe the daycare arrangements (e.g. grandparent on Tuesdays from 9am-5pm, nanny on Thursdays from 12-6pm in our home): ____
____
____

Please fill out an "Exchange of Information" form for us to communicate with other professionals regarding your child's assessment or therapy program, if you so desire.

By signing below, I am indicating that:
1) I have the legal right to make all decisions regarding my child's speech and language therapy program.
2) I am not withholding health or educational information that is known to me.

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3) I accept financial responsibility for all services requested and provided at Hamaguchi & Associates.

Parent's Name (print please) ____

Parent's Signature _________________________________Date____________

We look forward to getting to know your child and working with you!!

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