Hamaguchi & Associates
20111 Stevens Creek Blvd., #145
Cupertino, CA 95014
(408) 366-1098 ext 3# • fax (408) 366-1011
www.hamaguchiandassociates.com

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: ____
Pronunciation (if unusual): ____________________Nickname:____________________
Child's Last Name: ____
Pronunciation (if unusual): ____
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" and include a copy of the front and back of your insurance card. We will also need a physician's prescription for whatever service you are requesting (assessment, therapy, or both). Please remember that most insurance companies will not cover speech therapy unless it is "medically necessary." We will also need to send your physician a copy of any reports pertaining to your child's care.

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**__________

Copyright Hamaguchi & Associates 2018

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____

____

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:____

____

Normal pregnancy and delivery?
❑ Yes ❑ No ❑ Information unavailable
If no, please provide further information ____

____

Weight at birth (if known)? __________________

History of jaundice?_________________

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)?

____

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 the concerns you have about your child's speech, language or listening is the same in both languages?
❑Yes ❑No

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

- ❑ pronunciation If yes, what sounds is your child struggling with? _____________
- ❑ doesn't say real words yet
- ❑ talks very little
- ❑ mouth muscles/drooling
- ❑ chewing/swallowing

Copyright Hamaguchi & Associates 2018

- ❑ 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: (circle) behavior, playing with other children, following the class, crying
- ❑ 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

5. About Your Child

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 and games? ____

____

What upsets your child? ____

____

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? __________________

____

____

____

6. Developmental Milestones

Does your child walk independently?

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

How would you describe your child as a baby?

- ❑ A noisy babbler
- ❑ Babbled very little
- ❑ Screamed/cried/fussier than I expected
- ❑ A very laid-back, calm and happy baby
- ❑ Poor sleeper
- ❑ Easy sleeper
- ❑ Varied, please explain:__________________

Has your child begun to use any real words?

- ❑ Yes If yes, when do you recall the first real word was spoken? ____________________
- ❑ No

Copyright Hamaguchi & Associates 2018

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 typical words, phrases or sentences your child might say in a typical day. (If your child is not yet saying words, can you explain what sounds he/she is making?) _____________________
____
____

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

7. 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

Has your child ever been tested for lead poisoning?
❑
If yes, at what age? ________ Results_______________ (# micrograms per deciliter if known)

Any history of seizures?
- ❑ Yes Please explain what happened and at what age:________________________
- ❑ No

Any history of tonsilitis?
❑ Yes ❑ No

History of ear infections?
- ❑ Yes How frequent? Ventilation tubes? _____________________________
- ❑ No

Known vision problems? ____

Allergies? ____

Copyright Hamaguchi & Associates 2018

8. 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 (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

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: ____

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? _______________
- ❑ Occupational Therapy
  When? __________
  Was it helpful? _______________
- ❑ ABA Therapy
  When? __________

Copyright Hamaguchi & Associates 2018

Was it helpful? _______________
- ❑ Relationship Development Intervention (RDI)
  When? __________
  Was it helpful? _______________
  Was it helpful? _______________
- ❑ Counseling/Therapy
  When? __________
  Was it helpful? _______________
- ❑ Other: ____

9. 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
- ❑ Avoids eye contact
- ❑ 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 obsessive interests, repetitive movements, tics (e.g. blinking, sniffing, head movements, etc.) or behaviors (e.g. trains, maps, dinosaurs, hand-washing, Pokemon)?

- ❑ Yes Please list: ____
- ❑ No

Sometimes will:

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

Are there any other issues regarding behavior? ____
____

10. Oral-Motor/Diet & Nutrition

How would you describe your child's chewing and swallowing? (check all that apply)

- ❑ Typical for his/her age
- ❑ Messy for his/her age
- ❑ Chokes more than I would expect
- ❑ Has a very limited number of foods he/she will eat
- ❑ Avoids hard and crunchy foods
- ❑ Prefer carbohydrates
- ❑ Prefers foods with spicy flavors
- ❑ Prefers foods with salty flavors
- ❑ Prefers bland foods
- ❑ Stuffs lots of food into his/her mouth at once
- ❑ Drools when eating
- ❑ Drools at rest
- ❑ Has a big appetite-is always hungry
- ❑ Is hardly ever hungry
- ❑ Tends to eat snacks more than at meals
- ❑ Has a hard time sitting down for an entire meal
- ❑ Appetite is variable

Copyright Hamaguchi & Associates 2018

Is your child on a restricted diet?
- ❑ Yes
- ❑ No
- ❑ Previously, no longer

If yes, which kind?
- ❑ Gluten-free/casein-free
- ❑ Vegan
- ❑ Dairy free
- ❑ Diabetic/sugar-free
- ❑ Vegetarian
- ❑ 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):
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____

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

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

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

Does your child's tongue protrude (stick out) at rest?
- ❑ No
- ❑ Much of the time
- ❑ Occasionally
- ❑ Most/all of the time

Does your child have an IEP 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

Copyright Hamaguchi & Associates 2018

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): ____
____
____

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

Parent's Name (print please) ____________________________________

Parent's Signature ______________________________**Date**____________

Copyright Hamaguchi & Associates 2018