Hamaguchi & Associates
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Patient History Form

New Client: 6 Years and Older

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__________

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Parent(s) Status:
- ❑ Solo/single parent
- ❑ Legally married
- ❑ Living together
- ❑ Domestic partnership
- ❑ Living apart (If so, who is the primary legal custodian?)______________________________

Name and age of child's siblings____

2. Language History

Language(s) spoken in the home____
What is the language of the primary caregiver? ____________________________________
If English is the only language that has been spoken to your child, please skip down to #3 below.

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____

3. 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?
- ❑ Yes
- ❑ No

If yes, please explain____

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
- ❑ No

If yes, please explain ____

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? ___________________
____
____
____

Does your child read?
- ❑ Yes
- ❑ No

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If yes, how would you describe his/her decoding skills (figuring out the words)?

- ❑ Below age/grade level
- ❑ Above age/grade level
- ❑ At age/grade level
- ❑ Not sure

If your child reads, how would you describe his/her comprehension of what is read?

- ❑ Below age/grade level
- ❑ Above age/grade level
- ❑ At age/grade level
- ❑ Not sure

4. Previous Evaluations and Therapy

Has your child been evaluated or treated for a speech problem in the past?

- ❑ *Yes
- ❑ No

If yes, when and by whom?____

Please send us 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
- ❑ No

If yes, when and by whom?______________________________

Diagnosis: ______________________________

Is your child still currently receiving occupational therapy?

- ❑ Yes
- ❑ No

Where?

- ❑ Through school
- ❑ Through a private practice

Has your child been evaluated by a psychologist, educational therapist, or learning consultant?

- ❑ Yes
- ❑ No

If yes, when and by whom?____

Diagnosis/Recommendations:____

Has your child been evaluated by a neurologist?

- ❑ Yes
- ❑ No

If yes, when and by whom?____

Diagnosis/Recommendations:____

Has your child had a thorough hearing evaluation?

- ❑ Yes
- ❑ No

If yes, when and by whom? ____

Diagnosis/Recommendations: ____

Who is your child's primary physician?______________________________

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

- ❑ Typical for age
- ❑ Quiet
- ❑ Outgoing
- ❑ Tends to prefer playing alone
- ❑ Gets in trouble at school (Explain:________________________)
- ❑ Wants to play with others, but has trouble making or keeping friends

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- ❑ Says odd things (Example___________________________)
- ❑ Makes odd noises
- ❑ Prefers to play with younger children
- ❑ Tends to say/do socially inappropriate things for a child his age
- ❑ 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
- ❑ Has many fears (e.g. won't sleep alone, won't go into a public restroom alone, bugs
- ❑ Is talkative at home, but fairly quiet/shy in school
- ❑ Has social anxiety
- ❑ Gets depressed
- ❑ Likes to touch, tap or grab things he/she shouldn't, even after being told to stop
- ❑ Will ask you the same question over and over
- ❑ Will often do the exact opposite of what authority figures (parents/teachers) want them to do
- ❑ Doesn't respond to his/her name consistently
- ❑ Doesn't respond to his/her name if engaged in TV/video games (hyperfocused)
- ❑ Has obsessive interests or behaviors (e.g. trains, dinosaurs, hand-washing, Pokemon)
- ❑ Can be unusually argumentative
- ❑ Repetitive movements
- ❑ Tics (e.g. blinking, sniffing, head movements, etc.)
- ❑ Dislikes long sleeves, tags in shirts
- ❑ Sometimes will (please circle) bite, hit, scratch, kick other adults or children if unhappy

Any other issues regarding behavior? ____
____

6. 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?_________________

7. Developmental Milestones

When did your child walk independently?_______________________
When do you recall the first real word was spoken? ____________________
At what age did you first become concerned about your child's speech-language development and why?
____

8. Health History

Is your child presently taking any prescription medication?
❑ Yes ❑ No
If yes, please tell what it is and why it is taken ____________________

In the past, has your child taken medications to treat AD/HD (such as Ritalin, Concerta, or Stratera)?
❑ Yes ❑ No
If yes, for how long/when/was it successful? ____________________

In the past, has your child taken medications to treat neurobiological conditions such as obsessive compulsive disorder, anxiety or depression?
❑ Yes ❑ No
If yes, for how long/when/was it successful? ____________________

Does your child take any vitamins, supplements, or non-prescription medication?
❑ Yes ❑ No
If yes, please tell what it is and why it is taken __________ ____________________

Any major illnesses or surgery to date?
❑ Yes ❑ No
If yes, please explain ____________________

Has your child ever been tested for lead poisoning?
❑ Yes ❑ No
If yes, at what age? _________ Results________________ (# micrograms per deciliter if known)

Any history of seizures?
❑ Yes ❑ No
If yes, explain what happened and at what age:____________________

Any history of tonsilitis?
❑ Yes ❑ No

History of ear infections?
❑ Yes ❑ No
If yes, how frequent? Ventilation tubes? ____________________

Known vision problems? ____________________

Allergies? ____________________

Sleep:
What time does your child typically go to sleep? _________
What time does your child typically wake up? _________

Describe the sleeping patterns: (check all that apply)
❑ Sleeps in his/her own room
❑ Sleeps in the bed with us
❑ Sleeps on our floor
❑ Gets up at night: please describe how often and why (scared, can't sleep, misses you)
____

Does your child snore?
❑ Yes ❑ No

If yes, has your child been evaluated by a sleep specialist for sleep apnea?

- ❑ Yes
- ❑ No

Does your child seem sleepy during the day at times you wouldn't expect?

- ❑ Yes
- ❑ No

9. 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

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)____________________

If yes, 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.) ____

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? _____

10. Educational History

Tell us about your child's current educational program:

- ❑ public-school (Name/city:____)
- ❑ private school (Name/city:____)
- ❑ home-schooled (Name/city: ____)

- ❑ Regular classroom (Grade:_____)
- ❑ Special education classroom
- ❑ A combination of regular classroom mainstreaming and special ed

Please describe the current classroom setting: ____

Is your child receiving any special services through the public school IEP? Please check all that apply:

- ❑ speech therapy
- ❑ occupational therapy

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- ❑ resource teacher help in the classroom
- ❑ teacher aide in the classroom that assists your child
- ❑ adapted P.E.
- ❑ ABA Therapy
- ❑ assistive listening device
- ❑ augmentative communication device
- ❑ other:__________________________________

What are your child's favorite school subjects? (if any) ____

What are your child's least favorite school subjects? ____

What services has your child received privately?

- ❑ Lindamood-Bell programs When? __________ Was it helpful? _______________
- ❑ Tomatis Listening Therapy When? __________ Was it helpful? ________________
- ❑ Biofeedback When? __________ Was it helpful? _______________
- ❑ Tutoring When? __________ Was it helpful? _______________
- ❑ Social/Pragmatic Group When? __________ Was it helpful? _______________
- ❑ Occupational Therapy When? __________ Was it helpful? _______________
- ❑ ABA Therapy When? __________ Was it helpful? _______________
- ❑ Relationship Development Intervention (RDI) When? __________ Was it helpful? __
- ❑ Fast ForWord When? __________ Was it helpful? _______________
- ❑ Interactive Metronome When? __________ Was it helpful? _______________
- ❑ Auditory Integration Training (AIT) When? __________ Was it helpful? __________
- ❑ Rapid Prompting Method (RPM) When? ____________ Was it helpful? __________
- ❑ Cognitive-Behavioral Therapy (CBT) When? __________ Was it helpful? ________
- ❑ Counseling When? __________ Was it helpful? _______________
- ❑ Reading Tutoring When? ________ Was it helpful? ____________________
- ❑ Educational Therapy When? ______ Was it helpful? ____________________
- ❑ Naturopathy/homeopathy remedies When?_____ Was it helpful? ________ Which supplements did you use? ____
- ❑ Other: ____

Please tell about your child's school experiences (areas of strength, areas of difficulty, what's working, what's not)
____
____
____

Is your child currently in daycare for any part of the week?

❑ Yes ❑ No

If yes, 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.

Please be aware that Patti Hamaguchi will be reviewing and consulting on all cases that come into this office, regardless of the treating speech-language pathologist. Our staff meets regularly for case review/brainstorming and your child's therapy program may be reviewed, discussed or observed with other speech pathologists in our practice, aside from the treating SLP. If you have a shared custody arrangement or court order, we must have the other parent's signature in order to see your child, regardless of who is paying for it. If this is the case, you must let our front office know and the appropriate form will be given to you.

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____________

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