Communication Foundations LLC

Skills for life

www.communicationfoundations.com

(860) 853-0205

Client History Form

Please Print Legibly

CLIENT INFORMATION

Last Name: _____First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Age: _____years _____months

Please Circle: Male Female

Address: _____ City/Zip Code: _____

Pediatrician: _____ Pediatrician Phone:_____

School District/School:_____

Insurance Carrier: _____ ID #: _____

Primary Insured: _____ DOB: _____ Group #: _____

PARENT/GUARDIAN INFORMATION

1). Parent/Guardian Last Name: _____ First Name: _____

Relationship to Client: _____

Address (if different than client):_____

Phone (H): _____ (C): _____ (W): _____

Employer/Occupation: _____

Email Address: _____

May we email you? ☐ YES ☐ NO

2). Parent/Guardian Last Name: _____ First Name: _____

Relationship to Client: _____

Address (if different than client): _____

Phone (H): _____ (C): _____ (W): _____

Employer/Occupation: _____

Email Address: _____

May we email you? ☐ *YES* ☐ *NO*

Emergency Contact(s): _____ Phone: _____

Relationship to Client:_____

CLIENT DEVELOPMENTAL HISTORY

Pregnancy: (Please circle one). No Complications Complications
If complications, please explain: _____
_____
_____

Birth History: (Please circle one). Vaginal Birth Cesarean Section
If complications, please explain: _____
_____
_____

Feeding History: ☐ Complications ☐ No Complications
☐ Breast Fed _____months
☐Bottle Fed _____months
At what age did your child transition to solid foods? _____
☐Picky Eater ☐ Eats a variety of foods

At what age did the client:
Sit unsupported? _____Crawl? _____
Stand? _____ Walk? _____
Babble? _____ Use 1 word? _____
Put 2 words together? _____ Last hearing screening: _____

Does your child have frequent ear infections? Yes No

Are ear infections managed by: ☐ Antibiotics ☐ PE Tubes ☐ "Wait and See"

Does the client have any medical diagnoses?_____
_____
_____
_____

Please list any surgeries and dates of surgeries: _____
_____

Please describe your primary concerns:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list current services or services received in the past:

Type of Service (e.g. Speech/OT/PT BCBA, etc.)	**Date(s) of Service**	**How often? (e.g. 60 min/week)**	**Please Circle One**
			School-based Private
			School-based Private
			School-based Private
			School-based Private

Allergies: _____
_____
_____

Special Diet: _____
_____
_____

Current Medications/Supplements: _____

_____

_____

Favorite Toys/Activities: _____

_____

_____

What do you hope to gain from attending Speech Therapy? _____

_____

_____

_____

Name of individual completing this form: _____

Relationship to Client: _____