



Hamaguchi & Associates

20111 Stevens Creek Blvd., #145
Cupertino, CA 95014
(408) 366-1098 • fax (408) 366-1011
www.hamaguchianassociates.com

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

(Please complete and return this form at least 5 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 we should use _____
Pronunciation (if unusual) _____
Child's Last Name _____
Pronunciation (if unusual) _____
Date of Birth _____ Age _____ Male ___ Female ___
Address _____
City/Zip _____
Home Phone _____
Mother's/Guardian/Partner's Name _____
Occupation _____ Employer _____
Email: _____ Cell: _____
Father's/Guardian/Partner's Name _____
Occupation _____ Employer _____
Email: _____ Cell: _____
Do you intend to seek insurance reimbursement? ___yes ___no
How did you hear about our practice? _____

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 _____

Parent(s) Status:

____ solo/single parent ____ legally married ____ living together ____ domestic partnership
____ living apart/separated (If so, who is the primary legal custodian?) ____ divorced (If so, who is the primary legal custodian? How often does your child see the other parent?)

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)?
(Please start from birth and describe the languages and age the child was exposed to each language) _____

What settings is your child currently spoken to in English? _____ home (what percentage of the time? _____ %) school (what percentage of the time? _____ %)

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? _____ (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.) _____

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?

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

- pronunciation If yes, what sounds are your child struggling with? _____
- doesn't say real words yet
- talks very little
- mouth muscles/drooling
- chewing/swallowing
- sentence structure
- doesn't learn or remember new words easily
- doesn't look at people when they are talking to him
- 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 (pretend play)
- makes noises or says words but they don't make sense
- doesn't "show me" things ("Look, Mom!")
- doesn't call "Mommy/Ma" to get my attention
- likes to do things over and over and over
- repeats things
- doesn't relate to people normally
- doesn't point to pictures in books when requested
- doesn't respond to questions correctly

Other _____

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? _____

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 ___

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 ___

Often repeats phrases heard out of context ___

Doesn't respond to his/her name consistently ___

Does your child like to be hugged or cuddled with? ___ yes ___ no

Has obsessive interests or behaviors (e.g. trains, maps, dinosaurs, hand-washing, Pokemon) _____

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 _____ Adoption _____ Presently a foster child

For adopted/foster children:

If adopted or foster child, at what age 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 _____
*Please provide further information _____

Weight at birth if known _____ History of jaundice? _____

7. Developmental Milestones: *(If the information is unavailable, please indicate that below as N/A to indicate "not available.")*

When did your child walk independently? _____

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 _____ varied (explain more: _____)

Has your child begun to use any real words? _____ yes _____ no

If yes, when do you recall the first real word was spoken? _____

Did your child develop language/words and then lose them? _____ yes _____ no

When did you notice your child's language loss? _____

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? ___ no ___ yes (if yes, at what age? _____)

8. Health History

Is your child presently taking any prescription medication? (If yes, please tell what it is and why it is taken) _____

Does your child take any vitamins, supplements, or non-prescription medication? (If yes, please tell what it is and why it is taken) _____

Any major illnesses or surgery to date? no ___ yes _____ (please explain)

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

Any history of seizures? ___ If yes, explain what happened and at what age: _____

Any history of tonsilitis? _____
History of ear infections? (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? ___ no ___ yes (If yes, has your child been evaluated by a sleep specialist for sleep apnea? ___ no ___ yes)
Does your child seem sleepy during the day at times you wouldn't expect? ___ no ___ yes

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 or 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? no * yes +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.)

Please list the foods your child will typically eat for breakfast, including how it is prepared (e.g. cooked, chopped up, etc) _____

Please list the foods your child will typically eat for lunch, including how it is prepared:

Please list the foods your child will typically eat for dinner, including how it is prepared:

Please list the foods your child will typically eat for snacks, including how it is prepared:

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 ____ or bottle fed ____ both ____
Is your child weaned from the bottle/breast? _____ Is so, about what
age was your child weaned from the bottle? _____ from the breast? _____

Does your child's tongue protrude (stick out) at rest?
no ____ occasionally ____ much of the time ____ most/all of the time ____

Does your child have an IEP from the public schools? ____ *yes ____ no
If yes, what services is your child receiving? _____

Has your child ever attended a preschool/kindergarten program? 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
*If yes, please describe the daycare arrangements (e.g. grandparent on Tuesdays from
9am-5pm, nanny on Thursdays from 12-6pm in our home) _____

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

____ 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? _____
 ___ Cognitive-Behavioral Therapy (CBT) When? _____ Was it helpful? _____
 ___ Counseling When? _____ Was it helpful? _____
 ___ Other: _____

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** _____