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: ____
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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2. Family Information:

Parents/Guardians/Partners are:

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

Child lives with:

- ❑ Birth Parents
- ❑ One Parent
- ❑ Adoptive Parents
- ❑ Other________________________
- ❑ Foster Parents
- ❑ Parent and Step-Parent

Other children in the family:

Name: Age: Sex: Grade:

____

____

3. Child's Birth History:

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
- ❑ Information unavailable
- ❑ No

Please provide further information if needed:____

____

____

Weight at birth (if known)___________________

History of jaundice? _____

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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 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_________________________ ________________________________

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.) ____

What are your child's favorite activities and games?
____
____

What upsets your child? ____
____
____

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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
- ❑ Varied, please explain:_________________________

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?

- ❑ Yes Age? _____
- ❑ No

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7. 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?

- ❑ 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? ___________

History of ear infections? (How frequent? Ventilation tubes?)_____________________________

Known vision problems? ____

Allergies? ____

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:_____________________

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

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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? ________________
- ❑ 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? _______________
- ❑ Cognitive-Behavioral Therapy (CBT)
  When? __________
  Was it helpful? ________
- ❑ Counseling
  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
- ❑ 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

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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
- ❑ None of the above
- ❑ Will listen to stories with characters
- ❑ 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)?

____
____
____

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 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?

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

If yes, which kind?

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

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.)

____

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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
- ❑ Used to, but has stopped
- ❑ Yes, still does

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

Does your child use a pacifier?

- ❑ Never did
- ❑ Used to, but has stopped
- ❑ Yes, still does

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
- ❑ 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)

____

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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_____________

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