



Hamaguchi & Associates

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Patient History Form

(New Client: 6 Years and Older)

(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/singe 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)? (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?

- ___ a limited vocabulary ___ answering questions people ask
- ___ eye contact ___ talks very little ___ talks TOO much
- ___ jumps from topic to topic ___ needs to listen/attend better
- ___ difficulty having a normal conversation ___ sentences too short and simple
- ___ pronunciation ___ chewing/swallowing ___ mouth muscles/drooling
- ___ understanding language ___ following directions ___ learning new words
- ___ remembering what was said ___ listening with background noise
- ___ social language use ___ understanding idiomatic expressions/inferences/humor
- ___ putting grammatical sentences together ___ explaining what happened
- ___ retelling stories with a clear sequence, elaboration and detail
- ___ word retrieval/word-finding (says "uh—um"; has difficulty using words he already knows)
- ___ speaks slower than you'd expect ___ speaks faster than you'd expect
- ___ articulation (What sounds? _____)
- ___ asking questions in a clearer way ___ auditory processing/comprehension
- ___ speech intonation varies very little or goes up and down in the wrong places

___ listening with background noise ___ attention span ___ phonemic awareness
___ relating/communicating with other children in a more normal way(social/pragmatics)
___ stuttering-like speech ___ voice quality (pitch/hoarseness/nasal)

How long have these difficulties been an issue? _____

Does your child seem to be aware of these difficulties or express concern about the issues you described above?

Does your child read? ___ * yes ___ no
*If yes, how would you describe his/her decoding skills (figuring out the words)?
___ below age/grade level ___ at age/grade level ___ above age/grade level
___ not sure

*If your child reads, how would you describe his/her comprehension of what is read?
___ below age/grade level ___ at age/grade level ___ above 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? _____

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 recess _____ (Explain: _____)
Wants to play with others, but has trouble making or keeping friends _____
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 _____
Often repeats phrases heard out of context _____
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 _____ (in quiet)
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 _____ 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? _____

If yes, 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? (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? (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.)

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 ___

If so, please describe the current

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

___ speech therapy
___ occupational therapy
___ 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 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? _____

___ 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? _____

___ 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** _____