



Hamaguchi & Associates

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Patient History Form **(For Ages 6 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 services 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 _____

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 Parent and Step-Parent
 Adoptive Parents One Parent
 Foster Parents Other _____

Other children in the family:

Name: _____ Age: _____ Sex: _____ Grade: _____

5. 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? _____

3. 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

What areas below concern you at this time?

- | | |
|--|--|
| <input type="checkbox"/> A limited vocabulary | <input type="checkbox"/> Retelling stories with a clear sequence, elaboration and detail |
| <input type="checkbox"/> Answering questions people ask | <input type="checkbox"/> Word retrieval/word-finding (says "uh—um"; has difficulty using words he already knows) |
| <input type="checkbox"/> Eye contact | <input type="checkbox"/> Speaks slower than you'd expect |
| <input type="checkbox"/> Talks very little | <input type="checkbox"/> Speaks faster than you'd expect |
| <input type="checkbox"/> Talks TOO much | <input type="checkbox"/> Articulation: What sounds? |
| <input type="checkbox"/> Jumps from topic to topic | _____ |
| <input type="checkbox"/> Needs to listen/attend better | <input type="checkbox"/> Asking questions in a clearer way |
| <input type="checkbox"/> Difficulty having a normal conversation | <input type="checkbox"/> Auditory processing/comprehension |
| <input type="checkbox"/> Sentences too short and simple | <input type="checkbox"/> Speech intonation varies very little or goes up and down in the wrong places |
| <input type="checkbox"/> Pronunciation | <input type="checkbox"/> Facial expression/emotions/behavior/body language not appropriate to situation |
| <input type="checkbox"/> Chewing/swallowing | <input type="checkbox"/> Attention span |
| <input type="checkbox"/> Mouth muscles/drooling | <input type="checkbox"/> Phonemic awareness |
| <input type="checkbox"/> Understanding language | <input type="checkbox"/> Relating/communicating with other children in a more normal way (social/pragmatics) |
| <input type="checkbox"/> Following directions | <input type="checkbox"/> Stuttering-like speech |
| <input type="checkbox"/> Learning new words | _____ |
| <input type="checkbox"/> Remembering what was said | <input type="checkbox"/> Difficulty with writing sentences/stories |
| <input type="checkbox"/> Listening with background noise | <input type="checkbox"/> Difficulty with reading out loud (decoding) |
| <input type="checkbox"/> Social language use | <input type="checkbox"/> Difficulty with reading comprehension |
| <input type="checkbox"/> Understanding idiomatic expressions/inferences/humor | |
| <input type="checkbox"/> Putting grammatical sentences together | |
| <input type="checkbox"/> Explaining what happened | |
| <input type="checkbox"/> Voice quality (pitch/hoarseness/nasal) | |
| <input type="checkbox"/> Does not understand other's body language/facial expression/tone of voice | |
| <input type="checkbox"/> Difficulty with spelling | |
| <input type="checkbox"/> Other _____ | |

4. About Your Child:

Is there a history in the family of speech, language or learning disabilities of any kind, including Attention Deficit Disorder Or Autism?

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?

5. Developmental Milestones:

Information unavailable

When did your child walk independently? _____

When did your child first use meaningful words? _____

Is your child toilet trained? _____

Tends to use:

Right hand

Left hand

No preference yet

6. 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? _____

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 on our floor
 sleeps in the bed with us gets up at night

Please describe how often and why (scared, can't sleep, "misses you")

Does your child snore?

- Yes No

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

7. 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. Also, please provide us with a copy of any speech-language assessments/IEPs.

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 physical or occupational therapy?

Yes By Whom: _____ No

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

Yes No

Date: _____ By Whom: _____

Diagnosis: _____

Has your child been evaluated by a neurologist?

Yes No

Date: _____ By Whom: _____

Diagnosis: _____

Has your child had a thorough hearing evaluation?

Yes No

Date: _____ By Whom: _____

Diagnosis: _____

Please describe your child's present educational program/grade/name of school. Does your child have an IEP through the schools? _____

If having an assessment or therapy with us, would you like us to speak with the school's SLP to get more information about what tests have been done previously and to gather more information about what methods have already been used with your child?

Yes No

If yes, please list the speech-language pathologist's name, school address & phone number:

Did you decline special education services or evaluations that were offered in the public schools for your child?

- Yes No

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

- | | |
|--|--|
| <input type="checkbox"/> Lindamood-Bell programs
When? _____
Was it helpful? _____ | <input type="checkbox"/> Fast ForWord
When? _____
Was it helpful? _____ |
| <input type="checkbox"/> Tomatis/Listening Therapy
When? _____
Was it helpful? _____ | <input type="checkbox"/> Interactive Metronome
When? _____
Was it helpful? _____ |
| <input type="checkbox"/> Biofeedback
When? _____
Was it helpful? _____ | <input type="checkbox"/> Auditory Integration Training (AIT)
When? _____
Was it helpful? _____ |
| <input type="checkbox"/> Tutoring
When? _____
Was it helpful? _____ | <input type="checkbox"/> Cognitive-Behavioral Therapy (CBT)
When? _____
Was it helpful? _____ |
| <input type="checkbox"/> Social/Pragmatic Group
When? _____
Was it helpful? _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Occupational Therapy
When? _____
Was it helpful? _____ | <input type="checkbox"/> Counseling
When? _____
Was it helpful? _____ |
| <input type="checkbox"/> ABA Therapy
When? _____
Was it helpful? _____ | |
| <input type="checkbox"/> Relationship Development Intervention (RDI) | |

8. Social interaction and behavior (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Typical for age | <input type="checkbox"/> Unusually irritable or uncomfortable in noisy or crowded places such as malls, parties |
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Often repeats phrases heard out of context |
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Doesn't respond to his/her name consistently |
| <input type="checkbox"/> Tends to prefer playing alone | <input type="checkbox"/> Is bullied at school |
| <input type="checkbox"/> Prefers to play with younger children | <input type="checkbox"/> Misunderstands humor |
| <input type="checkbox"/> Tends to say/do socially inappropriate things for a child his age | <input type="checkbox"/> Seems to have a low-self esteem |
| <input type="checkbox"/> Is unusually active for his/her age | <input type="checkbox"/> Is unusually active for his/her age |
| <input type="checkbox"/> Has a shorter attention span than you expect for his/her age | <input type="checkbox"/> Has a peculiar sense of humor |
| <input type="checkbox"/> Avoids eye contact | <input type="checkbox"/> Can be annoying to classmates (unintentional or intentional) |
| <input type="checkbox"/> Is disinterested in other children | |

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:

- | | |
|-------------------------------|---|
| <input type="checkbox"/> Bite | <input type="checkbox"/> Scratch |
| <input type="checkbox"/> Hit | <input type="checkbox"/> Kick other adults or children if unhappy |

Are there any other issues regarding behavior or mental health issues(e.g. mood swings, displays anxiety, short temper, obsessive compulsive tendencies, depression, can be violent or unusually physically aggressive)?

When a referral is initiated by a physician, a report of our evaluation *must* be sent to him/her as a follow-up.

Parent Signature: _____ **Date:** _____